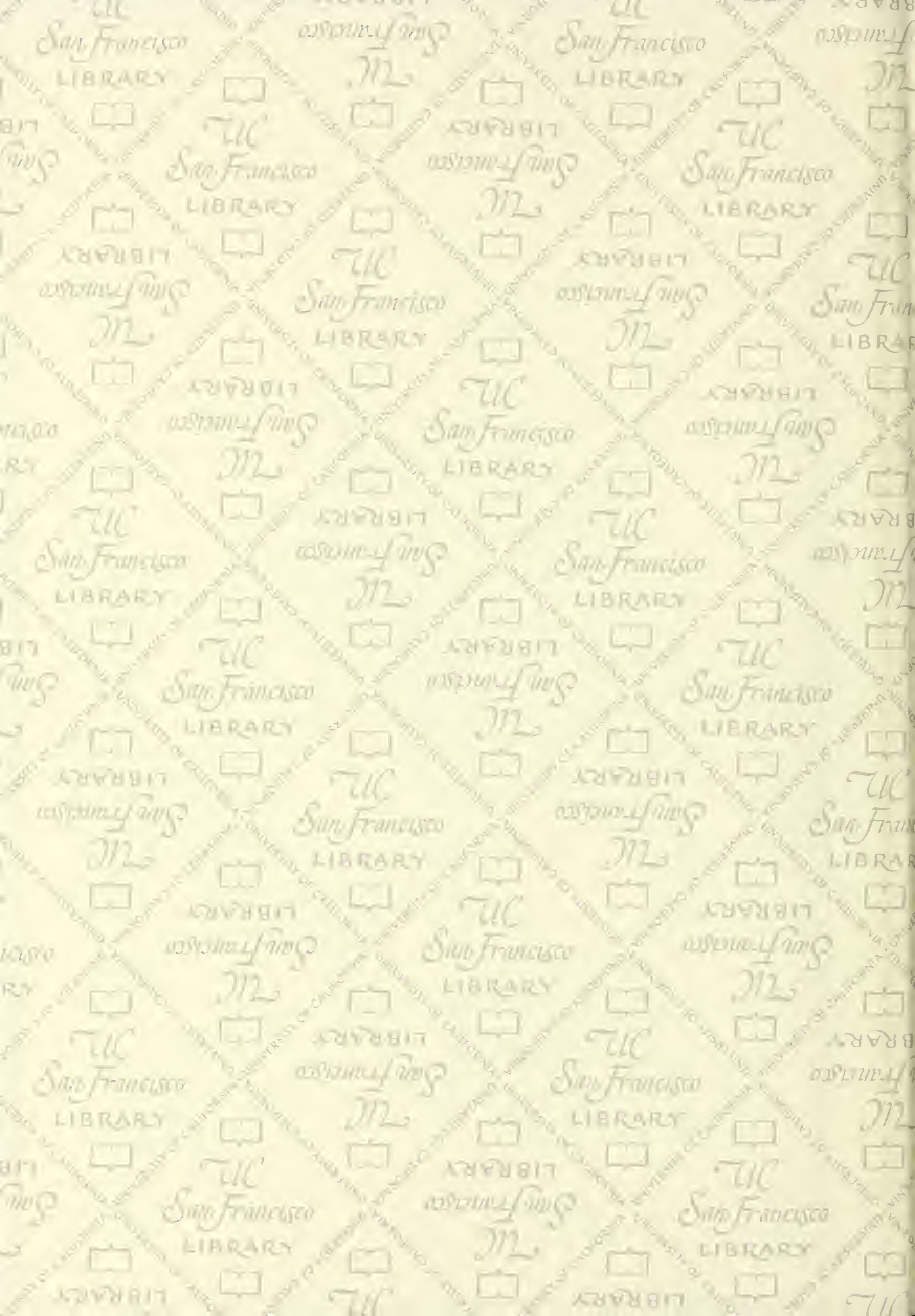
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MICHIGAN MEDICINE

JANUARY 1985 AWARD-WINNING JOU MEDICAL SOCIETY Vol. 84, No. 1

Maternal/ perinatal health: "A delicate balance"

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Michigan Conference on Maternal and Perinatal Health

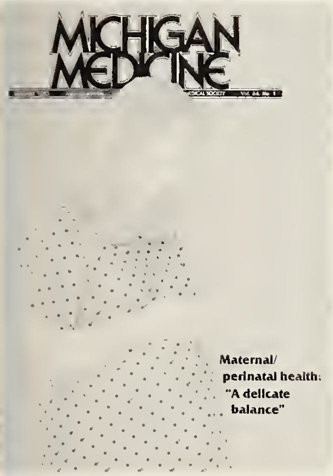
March 20-21, 1985
Hyatt Regency Dearborn

"Maternal/Perinatal Health: A Delicate Balance"

For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

January 1985, Vol. 84, No. 1

MICHIGAN MEDICINE



bout the cover:

taff member Donna Veara, ex-
ecting her first child in March,
our model for this month's
sue focusing on the Michigan
onference on Maternal and
erinatal Health. **Photo by Kim
auffman.**

**n next month's issue of *Michi-
an Medicine:*** Some say the cur-
ent professional liability climate
dicates another "crisis" is on the
orizon. How did we get here,
nd what does the future hold?
he February issue will look at the
roblem from several angles.

Special Report

5 The relatively high infant mortality rate in Michigan is a saddening and frustrating dilemma, but the situation may be improving thanks to the coordinated efforts of physicians and other concerned groups. This month's special report on the Michigan Conference on Maternal and Perinatal Health begins with an encouraging look at a new state law allowing minors to obtain prenatal care without parental consent. Then a physician leader in the maternal/perinatal health field discusses prevention of prematurity and resultant infant mortality. A special insert this month, the complete preliminary program for the 1985 Michigan Conference on Maternal and Perinatal Health, includes course descriptions and a registration form: Judy Marr; Hermann A. Ziel, Jr., MD.

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By Harvey Andre, MD

Excellent care at a fair price *is* possible

Doctor Andre

We all recognize the fact that medical care delivery is changing rapidly. From present trends, it seems as though all treating physicians eventually will be part of some type of group, be it a PPA, PPO, or HMO. All of us will find ourselves practicing in a competitive price structure.

In order to carry out our principal concern, the best possible delivery of health care, we must fight those who put cost above quality of care, particularly large organizations looking to increase their share of the market by advertising that they deliver health care for fewer dollars than anyone else.

As individuals we can do little or nothing about this problem. Together, as an organized medical profession, we can do *much* more. Excellent medical care *can* be provided to the public at a fair price, and providers of that care need not be made financial scapegoats of organizations, political groups, or persons seeking their own aggrandizement by selling a bill of goods to the public.

Michigan State Medical Society is working to guarantee you the best possible atmosphere in which to practice.

This sweeping change in health care delivery involves *all* doctors, and MSMS dues-paying members are fighting the battle for *all* doctors. What about the non-members? They are doing nothing to help the cause, but will get the same benefits. There are more than 13,000 MDs licensed in the state, and 10,937 MSMS members. It is time for each and every one of us to identify non-members and to encourage them to join organized medicine.

Will you do your part?

Doctor Andre, Grand Rapids, is chairman, MSMS Committee on Publications.

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Managing Editor
Sheri W. Greenhoe

Michigan Medicine, the official journal of the Michigan State Medical Society, i dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editoria board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or featur published in the pages of the journal. Th views expressed are those of the writer and not necessarily official positions of the society. Products and services adver tised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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18 66

lentifying health care ost culprits

e following letter recently was ceived by MSMS President ouis R. Zako, MD.

ove it. Your page in the October sue of the Michigan State Medi- l Society Journal is the most citing, and cogent editorial I ve ever read in that publication. e amount of territory you co- red - with so few words - is solutely remarkable. You, too, ust have read *The Painful Pre- ription* by Aaron and Schwartz, d I echo many of your feelings the problems of medical alth care costs. Even if all the arlatains were eliminated, and aste could be effectively con- olled, it wouldn't really make a ent on the medical care costs this country. I am certain, too, at DRGs, PPOs, HMOs, and all e rest of this alphabet soup will down the drain someday, here it belongs.

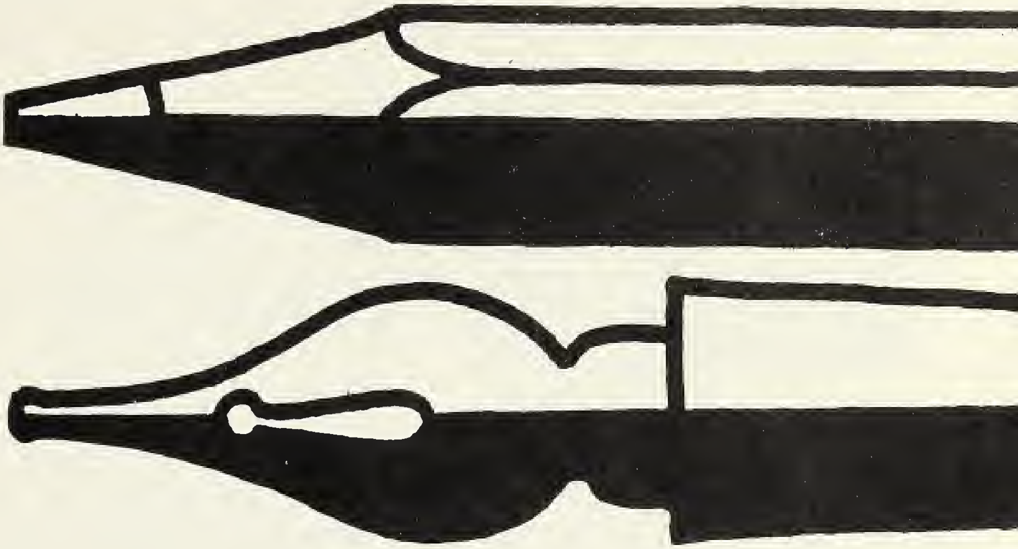
The real culprits, of course, are e CT scanners, the PET scanners, e NMRs, the monoclonal anti- dy research, etc., that I am sure e citizens of this country are not illing to give up, not even at this me. I think, too, that there is a ghtful place for deductibles and payment, even though these ill not cause a significant re- uction in medical care costs; wever, I am certain that they ill help induce some self-re- raint on the part of the patient pulation, as well as helping to ake their expectations a lot ore realistic.

Keep up the good work - ou're great.

A.B. Solomon, MD
Lathrup Village

PMLC's standards emain unchanged

the November issue of Michi- an Medicine, Dr. Joseph Heitsch Clarkston wrote that: "The in- urance companies in Michigan ave started to cancel out phy- cians who they feel have an nacceptable frequency, or sev- rity of claims made against em."



Speaking for Michigan Physicians Mutual Liability Company: MPMLC has not substantively changed its underwriting, or risk selection standards, in the last eight years. We have always strived to be a professional liability insurance source for all reasonably insurable Michigan physicians; we expect to continue to be that source.

David Sloan
Vice-President, Underwriting
Stratton-Cheeseman
Management Company

UP physician reacts to GM PPO

It was interesting to read in the November 29 Medigram concerning Dr. Sell's remarks concerning the auto manufacturers, especially GM's new PPO.

I wish that someone would ask Doctor Sell specifically what the GM employees will expect when they come to the Upper Peninsula on their vacations and require medical care. I anticipate a great deal of difficulty for those subscribers given the hard nose attitude which Doctor Sell apparently expressed to you in your interview quoted in that issue of Medigram.

If you care to enlighten us outlanders about such problems, we would be happy to hear from you.

Duane L. Waters, MD
Manistique

P.S. We in the UP would be glad to have our fees fixed at the same rates as those current in the Southfield area.

Larry J. Sell, MD, BCBSM vice president and medical director, sent the following response to Doctor Waters' P.S.

Screen increases were frozen in Southeastern Michigan from 1979 to October, 1983. At the same time physicians in the outstate area, which includes Manistique, continued to receive screen increases. As a result, screens for physicians in the southeastern part of the state are 10.5% less than those in the outstate regions.

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POLITICAL
ACTION
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Thomas E. Stone, MD, Chairman, MDPAC

By Judy Marr
Editor

New law removes one barrier or teens seeking prenatal care

What does a 14-year-old do if she becomes pregnt?

Some typical responses, Rep. na Stallworth, (D-Detroit) ints out, are rejection of reality d abortion. But pregnant teens dom seek medical care.

Because of this, Rep. Stallworth onsored legislation last year to move one of the barriers to pretal care for these young men.

HB 4708, which became Public t 153 on June 21, waives the quirement of parental consent minors to obtain prenatal and egnancy-related medical seres. The consent of the minor w is sufficient to obtain a phyian's care for herself or for her ld.

An important corollary, then, is t physicians who provide pretal care to minors no longer ed to fear lawsuits.

Why the need for such a bill? "Every family has a different ue system," notes Rep. llworth, herself a mother of o and grandmother of two. "Some are free and open, and innately provide support. Others are traumatized by the pregnancy situation and can't deal with it."

"Such a high percentage of young, pregnant girls don't go to their parents. They fear the questions and thus do not get care until late in their pregnancies. And that is too late."

The costs are high when expectant mothers do not get medical care, the four-time legislator said.

"The problem is very costly to society in terms of high infant mortality rates for uncared-for mothers," she said. If those mothers come from uninsured families, regardless of the outcome of the pregnancy, "Michigan pays the bill."

"Most tragically, we pay to care for infants born with special needs which might have been taken care of if the mother had had good medical care from the beginning. So it is good for us to change the law to help ameliorate this problem," she said.

Rep. Stallworth began the process to change the law in April, 1983, after she became aware of the magnitude of the infant mortality problem in Michigan. As a member of the House Public Health Committee, she researched the problem, and found there were several groups working toward solving it.

"The fallout of my research was that there were two major barriers," she recalls. "One was the cost factor—the problem of paying for prenatal care for these minors—and the other was the issue of parent notification."

Regardless of solutions to the financial problem, said Rep. Stallworth, "there was still the gap: 'How do I go to the doctor without my mother?'

"So, this legislation should help achieve our ultimate goal—to get these people to their doctors."

A telephone survey of obstetricians/gynecologists revealed only sketchy knowledge of the bill, but general support, among the physician population.

Continued on next page

NEW LAW/continued

"I think the law is excellent. I agree with it," said Marsha Rohrer, MD, medical director of the Ingham County family planning and prenatal clinics. "People delay care if they have to have parental consent."

She and others interviewed said they always had provided prenatal care to minors on the basis of need, whether legal or not.

"We went ahead and did it because we thought it was the right thing to do," said Doctor Rohrer. "But those of us at the clinic are very happy the new law has passed because we think it will make changes in areas where people were not providing care. Those who were turning away minors will hopefully see them now."

Indeed, Rep. Stallworth emphasized that the major goal of the new law is to make the medical community's response to minors more uniform across the state.

"We know of inconsistencies," she said. "There are hospitals and clinics that get more than their share of pregnant minors. This drives their costs up, and sometimes the time before reimbursement can be too long."

"If these cases can be more integrated throughout communities, then we will do better in controlling the infant mortality problem."

Other physicians, such as Federico Mariona, MD, director, division of maternal/fetal medicine at Hutzel Hospital, Detroit, doubt that the barriers which prevent young women from seeking prenatal care will disappear with the passage of the new law.

"They will seek care earlier *only* if they understand the importance of getting care. The barrier is that if they realize they're pregnant, their reaction is to hide it, or terminate it, rather than to get care.

"The barriers are almost monumental. I'm not sure they are going to be overcome by a law which says they can get prenatal care. They're not going to get it unless we make it more available to them."

"The flaw is that we're trying to improve care for something which shouldn't have happened in the first place," he said. "This group of women should understand that this (pregnancy) is no a timely event for them. So I would remove other barriers for we physicians to achieve *that* goal, rather than removing one barrier too late.

To this, Rep. Stallworth repliec "We have *both* problems. No on denies we need preventative programs. But people seem to hav difficulty selling them, because we still run into the parental prerogative.

"We need to get parents stimulated to reinforce education before we can begin to redirect th focus. Until we address that problem it is going to be difficult to change things."

Rep. Stallworth *does* have several ideas for changing things, however.

She's begun to implement a small scale program in Detroit. She plans to enlist teen mother from the Lulabelle Stewart Cente to provide information and pee counseling at the five Detroit hig schools with the highest incidences of teen pregnancy and infant mortality.

She is encouraged by a New Detroit plan for a city-wide conference on teen pregnancy, anc is working with the Detroit Branc of the National Black Child Development Group on a "speak-out for youth" program focusec on teen pregnancies. And, she' promoting the Wayne County Ir fant Health Coalition's "A Healt Baby Begins with You" educational campaign. Rep. Stallwort wants the medical profession tc help by preparing informational brochures and public service announcements.☐

Infant mortality facts

Experts gathered at an MSMS/Detroit Medical Society meeting Dec. 19 predicted that the Detroit-area perinatal mortality rate could rise as high as 24 deaths per 1,000 live births in 1984.

The national perinatal death rate in 1983, the last year for which rates are available, was 10.9 deaths in 1,000 live births. In Michigan, the rate was 11.8.

In 1983, Detroit black perinatal mortality rates were 23.1 per 1,000, which was identical to national rates for blacks.

Despite some new programs to reach pregnant women, the mortality rate in some Detroit areas is now more than 30 per 1,000, which approaches the rate of Third World countries.

Jeffrey R. Taylor, PhD, chief of maternal and child health in the Michigan Department of Public Health, noted that the rate is two and a half times greater among blacks than among whites.

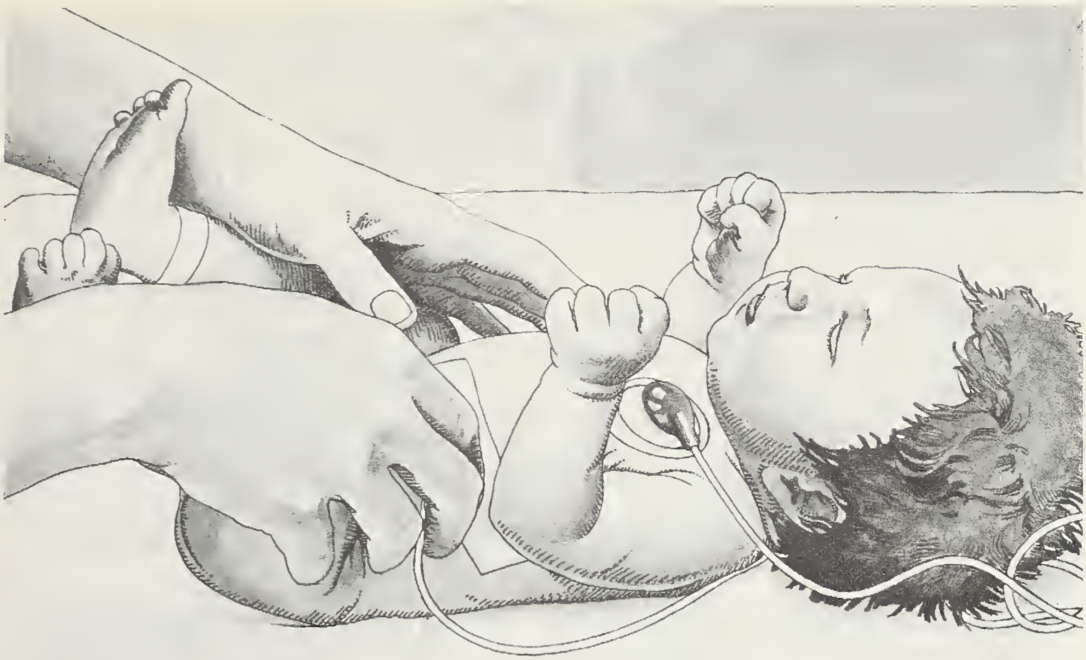
Major causes of the high Detroit-area rate, city Health Director John Waller, MD, told the media, are poor prenatal care and the large number of teenage pregnancies. Fifteen percent of all black women delivering in Detroit make fewer than five prenatal visits to their physician.

"Our ICUs do as well as those in any other countries," said Stephen B. Blount, MD, director, Office of Epidemiology and Biostatistics, Detroit Department of Health, who also attended the Dec. 19 meeting. "It's just that we have too many small babies."

Between 6.8 and 7.2 percent of Michigan babies are born with low birth weights, while Detroit area black babies hold the unenviable statistic of 15 percent.

"Economic activity is the prime underlying factor, and the widening gap between whites' and blacks' economic status is particularly marked in Detroit," said Doctor Blount.☐

By Hermann A. Ziel, Jr., MD



Prevention of prematurity and resultant infant mortality

Low birthweight is the leading
cause of newborn illness and
eath. Preterm birth (delivery be-
re the 37th week of pregnancy)
the leading cause of low birth-
eight. As many as two-thirds
all infant deaths appear to be
lated to the problems sur-
unding prematurity and low
rthweight.

During the 1970s, Michigan as
ell as most states throughout
e nation made enormous prog-
ss in reducing infant mortality.
any of the experts, including
ur own Michigan Center for
ealth Statistics, attribute ap-
oximately 85-90% of the de-
ne to improved survival rates
r low birthweight babies. In fact,
rvivability increased in nearly
birthweight classes. This is
ought in large measure to be
ue to the regionalization of
erinatal care. The ability to identify pregnant women at risk, to manage these pregnancies more effectively and to conduct total life support on seriously ill neonates have all contributed to these improvements.

The gains, however, have not been satisfactory in all areas of Michigan. For example, in 1983 Detroit reported almost 20 infant deaths per 1,000 live births as compared to a statewide average of just over 11. The black infant mortality rate in Detroit stands at approximately 23 per 1,000. This means that the black infant mortality experience approximates that of the Michigan general population in the late 1960s. It is unacceptable for any geographic area or for any ethnic group to be mired in infant mortality rates which are 15 or more years behind that of the general population. If we are to make important gains in the 1980s to reduce prematurity, low birthweight and resultant infant mortality, the answer is obvious: We must improve birthweights and reduce prematurity.

There are five major factors which undergird our high incidence of low birthweight. They are poverty, unemployment and low socio-economic status, unplanned pregnancy, late, inadequate or poor quality prenatal care, poor maternal, fetal and newborn nutrition, and substance abuse, including cigarette smoking, alcohol and drug abuse.

There has been some indication in the medical literature that prenatal care improvements can produce better birthweights and lower infant mortality rates. In programs such as MIC-PRESCAD in Detroit, medical care is supplemented by public health nursing, nutrition counseling, medical social work and health education. In a review of similar projects in outstate Michigan, it was determined that high risk patients can have their own perinatal death

Continued on next page

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octor Ziel is chairman of the MSMS
ommittee on Maternal and Perinatal
ealth.

Here's what MSMS is doing about it

MSMS is in the forefront of groups working to better the care of mothers and infants.

One of the medical society's most active branches is its Committee on Maternal and Perinatal Health. The committee meets quarterly, and its written records extend back 50 years.

With the committee's groundwork and leadership, MSMS has played a major part in some impressive medical care gains in this area:

- MSMS established the Placental Tissue Registry in 1970, the first statewide referral center of its kind in the nation, and a major source of data on the condition of the placenta in the birth of Michigan babies.
- MSMS developed and publicized its Guidelines for Regionalized Perinatal Care in 1982, which are being implemented across the state as they gain acceptance. They are designed to provide the best care at the most appropriate medical centers, without infringing on the privileges and advantages of the local hospital.
- MSMS established its Michigan Maternal Mortality Study, providing an annual review of deaths related to the birthing process, and sharing its statistics with the Michigan Department of Public Health.
- MSMS and the Michigan Chapter, American College of Obstetrics/Gynecology, developed a position statement on the role of the nurse midwife which stands as a guide for physicians across the state.
- Committee members and their leaders were among the first to study and interpret for their fellow physicians the commonly-accepted standards for perinatal care such as the Apgar score, PKU test, ultrasound for fetal monitoring and the caesarian section in difficult deliveries.

Chairs of the committee have included the distinguished Lee B. Stevenson, MD, Detroit; the late William Jack, MD, Grand Rapids; James E. Harryman, MD, Muskegon, and the late Richard Mellis, MD, Kalamazoo.

Today, under the leadership of Hermann A. Ziel, Jr., MD, Lansing, the committee continues to be guided under capable leadership.

Doctor Ziel heads MSMS efforts to bring down the high infant mortality rate in some of Michigan's major cities. He is teaming with leaders of the Detroit Medical Society to intervene and protect babies' lives.

The committee's Education Subcommittee periodically publishes Maternal Health Desk Reference Cards, which present the latest in treatment guidelines.

Committee members work regularly with the Michigan Department of Public Health; Michigan Chapter, American Academy of Pediatrics; Michigan Chapter, Obstetrics/Gynecology Society; Perinatal Association of Michigan and American College of Obstetricians and Gynecologists.☐

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rates substantially reduced through the use of team care. (*Perinatology-Neonatology,* September 1983).

One of a few recent innovations has been reported by Doctor Robert K. Creasy of the University of California at San Francisco. He developed a pre-term labor intervention program whic involves a three-pronged approach. Obstetricians and nurse are trained to identify high risk pregnant women with a special scoring system and then train t patients to detect the subtle sig of pre-term labor. This then allow intervention in the form of bed rest and labor inhibiting drugs. In the first three years of the experiment, the pre-term birth rat was reduced by nearly two-thir

Dr. Creasy's program now is undergoing comparison testing in five university centers throug out the United States with funding from the National Foundati for the March of Dimes, and th program has been adopted by the State of Florida.

In Michigan, the State Healt Department is working with th Detroit City Health Departmen to examine the possibility of installing Dr. Creasy's program in selected census areas of Detro For example, we know that Detroit Census Area A, which is bounded by West Grand River, Woodward and the Detroit Riv has a four year average infant mortality rate of 31.8. This mortality rate is far worse than som third world countries. If the program is to be successful, it will require close cooperation between public health officials, hospitals, physicians and nurse

While these are only a few potential avenues for further exploration in the area of prenat care, there are many other effo which could be undertaken. Expansion of family planning services, improved nutrition and substance abuse prevention ar other areas which need to be a dressed. Environmental hazard control also needs attention, a lead-contaminated dwellings remain a major problem.☐

Michigan Conference on Maternal and Perinatal Health

March 20-21, 1985
Hyatt Regency Dearborn

"Maternal/Perinatal Health: A Delicate Balance

A complete preliminary program

Goals and Objectives for the Michigan Conference on Maternal and Perinatal Health

The perinatal health care professional, through attendance at this conference will have an opportunity to interact with a multidisciplinary faculty addressing issues in perinatal health care. At the end of the conference, the participant should be able to:

- identify changes in the health care system that have had significant influence on the interdependent role of nursing and medicine in health care.
- discuss the ethical issues involved and the effectiveness of a multi-disciplinary health team approach in dealing with the family that suffers a perinatal loss and/or the malformed infant.
- delineate causes and discuss treatment in the management of post-partum bleeding, including ultrasound technology.
- describe the effects of prolonged pregnancy and its management.
- discuss the risks to and management of infants born to drug dependent mothers, the low birthweight infant and the fetus of a mother with sexually-transmitted disease.
- list the indications for consideration of in-vitro fertilization and describe the procedure.
- cite methods that can be applied by physicians and nurses which can help avoid potential litigation.
- describe the effect of pregnancy on dermatologic diseases.
- describe methods and approach to fetal assessment using biophysical techniques for assessment.
- describe recent advances and research in molecular genetics, the efficacy of artificial surfactant therapy in newborn RDS, the implications of high frequency ventilation in neonatal respiratory disorders, and new methods of diagnostic techniques for obstetric and gynecologic infections.
- list inborn errors of metabolism in the newborn where rapid diagnosis may permit life saving interventions with specific therapy.
- list the potential advantages of chorionic villi sampling in early pregnancy genetic diagnosis.

It is believed that interaction with other participants in the conference will offer broadened perspectives to those practicing perinatal medicine.

The Maternal and Perinatal Health Conference Planning Committee

Rudi Ansbacher, MD, Co-chairman, Ann Arbor
Robert W. Dustin, MD, Co-chairman, Dearborn
John R. Addy, MD, Lansing
C. Arch Brown, MD, Flint
Karen Brown, RN, MS, Bay City
Mary M. Conklin, RN, Lansing
Miriam S. Daly, MD, Albion
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Leonard L. Radecki, MD, Grand Rapids
Walter Schoen, MD, Ann Arbor
Mary A. Scoblic, RN, Lansing
Lloyd A. Kammeraad, MD, ex-officio, Grand Rapids
Hermann A. Ziel, Jr., MD, ex-officio, Lansing

Wednesday morning, March 20

:15 to 8:30
Velcome to the 24th Annual onference"
loderator: Hermann Ziel, Jr., D, Chairman, MSMS Commit- e on Maternal and Perinatal ealth, East Lansing

:30 to 9:15
The Nurse/Physician Relation- hip"
larilyn Poland, PhD, RN, Assis- nt Professor, Department of bstetrics and Gynecology, Vayne State University School f Medicine, Detroit
elationships between nurses nd physicians have become rained in recent years because f changes in our system of ealth care and the new roles and xpectations for women. The hanges in professional roles of urses and physicians over the ast 50 years will be explored as ey relate to their current re- tionship.

:15 to 10:00
Perinatal Loss - A Multidiscip- nary Approach"
ames R. Woods, Jr., MD, As- ociate Professor and Director of bstetrics, Department of bstetrics and Gynecology, Uni- ersity of Cincinnati Medical Cen- r, Ohio
regnancy loss shatters family dreams. A perinatal support service should provide medical, genetic, and emotional counseling. This presentation evaluates the effectiveness of such a program.

10:00 to 10:15
Question and Answer Session:
Doctors Poland and Woods

10:15 to 10:45
Break

10:45 to 11:45
"Management of Post-Partum Bleeding"
Robert H. Hayashi, MD, Professor and Chief of Obstetric Division,
Harbor/University of California, Los Angeles Medical Center
Prostaglandins - Obstetric Health care teams should be alert to significant post-partum bleeding. Multiple birth, oxytocin-induced or augmented labors, magnesium treated preeclampsia and precipitous labors are at-risk situations. When routine management fails, prostaglandins should be considered prior to more aggressive therapy.
Chang Y. Lee, MD, Clinical Associate Professor, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor
Ultrasound - Retained placental tissue and blood clots can be identified by ultrasound. This technology leads to early evacuation of retained tissue before excessive blood loss, and permits conservative treatment when tissue is not retained in the uterine cavity.

11:45 to 12:00
Question and Answer Session:
Doctors Hayashi and Lee

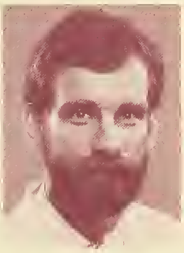
12:00 NOON
Adjourn to Luncheon Meetings:

"Ethics in Relation to the Malformed Fetus"
J. Robert Willson, MD, Adjunct Professor, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque
Our increasing ability to identify developmental anomalies before birth and to perform corrective operations on the fetus has raised many ethical issues. More importantly may be management of the tiny newborn. Everyone practicing obstetrics must develop an individualized approach incorporating family needs, legal aspects, and ethical considerations.

Continued on next page

lvio ladjem, MD

Sheila Norris Berkemeyer, RN, MSN


Richard A. Bowerman, MD

Joseph R. Custer, MD

Steven M. Donn, MD

Maria Ferraro Hayes, MD

Register for courses on page 16

WEDNESDAY LUNCHEONS/ continued

"Prolonged Pregnancy"
Robert H. Hayashi, MD, Professor and Chief of Obstetric Division, Harbor/University of California, Los Angeles Medical Center

Prolonged pregnancy may lead to utero-placental insufficiency requiring fetal tests of well being. Current management will be discussed.

"Neonatal Nursing: Beyond Baby Bottles and Diapers"
Molly R. Gates, RNC, MSN, Perinatal Outreach Coordinator, University of Michigan, Women Hospital, Ann Arbor

Advances in technology and sc ence have dramatically altered nursing care of babies. Today's nursery nurse has increased responsibility and accountability f assessment, intervention, and parent education. Numerous o portunities for specialization wit in neonatal nursing continue to evolve and will be discussed.

"The Addicted Fetus and Newborn"
Enrique M. Ostrea, Jr., MD, Chi of Pediatrics, Hutzel Hospital, D troit

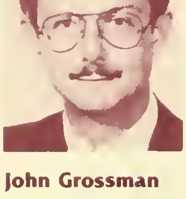
Recognition of perinatal risks o the infant born to a drug depe dent mother, withdrawal manifestations and their treatment w be addressed.

"The Obstetric Nurse Practitioner"
Evelyn Piehl, RN, MSN, Clinical Nurse Specialist-Obstetrics, University of Michigan, Women's Hospital, Ann Arbor

The focus and scope of advance clinical nursing practice require expanded knowledge, skills, increased responsibility and accountability. Role definition, ed cational preparation, certificatio and description of nurse practitioners in obstetrics and gynecology will be discussed.

John V. Hartline, MD

Molly Gates, RNC, MSN



John Grossman III, MD, PhD

Ruth Hanno, MD

Beverly J. Hires, RN, JD

Chang Y. Lee, MD

"Maternal/Perinatal Health: A Delicate Balance"

Wednesday afternoon, March 20

"Care of the Very Low Birthweight Infant"

oderator: John V. Hartline, D, Chief, Department of Pediat- s and Neonatologist, Bronson ethodist Hospital, Kalamazoo

5 to 2:30
bstetrical Aspects"
derico G. Mariona, MD, As- ciate Professor, Department of stetrics & Gynecology, Wayne te University School of edicine, Detroit

e antepartum and intrapartum nagement of the very low thweight infant has become an reasingly critical dilemma for perinatal team.

e changes occuring in the neo- al period can be influenced by peripartal events and, there- e, an understanding of them essential. It is critical to select optimal delivery technique and ting to avoid trauma and oxia, and to implement im- diate and appropriate neo- al support.

0 to 3:15
ursing Aspects"
eila Norris Berkemeyer, RN, N, Practitioner/Teacher, De- tment of Pediatric Nursing, Rush University, Rush-Presbyterian-St. Luke's Medical Center, Chicago

Very low birthweight infants are susceptible to numerous iatrogenic and environmental hazards. A "minimal handling" approach to nursing care of very low birthweight infants is an effective strategy for ensuring minimal stress with this fragile population.

3:15 to 3:45
Break

3:45 to 4:30
"Neonatal Aspects"
Ronald Poland, MD, Associate Professor of Pediatrics, Wayne State University School of Medicine and Director, Newborn Unit, Children's Hosptial of Michigan, Detroit

The challenges for care of very low birthweight infants include problems of temperature control, fluid balance, nutrition, management of the ductus arteriosus, prevention of retinopathy of prematurity (if possible) and management of severe pulmonary insufficiency while avoiding chronic lung disease. A tertiary care experience will be presented.

4:30 to 5:00
Panel Question and Answer Session:
Ms. Berkemeyer and Doctors Mariona and Poland

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity, the Michigan Conference on Maternal and Perinatal Health, meets the criteria for a maximum of 13 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

erico G.
iona, MD

Enrique M.
Ostrea, Jr., MD

Marilyn
Poland, RN, PhD

Ronald L.
Poland, MD

Patricia
Rogus, RN, BSN

Robert E.
Schumacher, MD

Register for courses on page 16

Thursday morning, March 21

7:30 Registration
Moderator: Silvio Aiadjem, MD, Maternal-Fetal Specialist and Director, Perinatal Services, Bronson Methodist Hospital, Kalamazoo

8:15 to 9:00
“In-Vitro Fertilization”
Maria Ferraro Hayes, MD, Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit
Patricia A. Rogus, RN, BSN, Clinical Coordinator, In-Vitro Fertilization, Wayne State University School of Medicine, Detroit
Indications for in-vitro fertilization include: tubal disease, endometriosis, oligospermia, immunologic infertility and unexplained infertility. In-vitro fertilization incorporates the expertise of physicians, nurses, basic scientists, and allied health professionals.

9:00 to 9:15
Question and Answer Session:
Doctor Hayes and Ms. Rogus

9:15 to 10:00
“Sexually-Transmitted Diseases in Pregnancy”
John H. Grossman, III, MD, PhD, FACOG, Associate Professor of Obstetrics and Gynecology, and Microbiology; Director, Division of Maternal-Fetal Medicine, The George Washington University School of Medicine and Health Sciences, Washington, DC
Venereal diseases continue to be a major health problem. When sexually-transmitted infections complicate pregnancy, medical management must concern itself with both mother and fetus. This presentation will update clinicians concerning the approach to both “traditional” and “non-traditional” sexually-transmitted diseases in pregnancy as they affect the fetus and mother.

10:00 to 10:15
Question and Answer Session:
Doctor Grossman

10:15 to 10:45
Break

10:45 to 11:30
“Malpractice in Obstetrics - Legal Aspects”
J. Robert Willson, MD, Adjunct Professor, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque and **J. Douglas Peters, JD,** Partner, Charfoos, Christenson, Gilbert and Archer, and Adjunct Professor, University of Toledo College of Law and Wayne State University School of Medicine, Detroit.
Preventing malpractice by better informing physicians as to standards of care as it relates to their training and professional ability will be addressed. Avoiding potential litigation by establishing reasons for diagnosis, management options and keeping caref records can be accomplished. Cases relating to these differen aspects will be presented.

11:30 to 12:00
Question and Answer Session
Doctor Willson and Mr. Peters

12:00 NOON
Adjourn to Luncheon Meetings:

“Dermatologic Problems in Pregnancy”
Ruth Hanno, MD, Staff Dermatologist and Dermatopathologist, Henry Ford Hospit Detroit and Clinical Assistant Professor, Department of Dermatology, University of Michig Medical School, Ann Arbor
This session will focus on the management of skin changes i pregnancy. Common disorders as well as dermatoses with potential maternal and fetal morbidity will be discussed.

“Ethical Decisions Related to t Handicapped Newborn”
Mason Barr, Jr., MD, Professo of Pediatrics and Director, Teratology and Birth Defects R habilitation, University of Michigan Medical School, Ann Arbo
Dilemmas encountered in deali with handicapped newborns a illustrated by actual cases. Dec sion making remains difficult, controversial and open to challenge.

“Fetal Activity and Well-Being
Chang Y. Lee, MD, Clinical Associate Professor, Department Obstetrics and Gynecology, U versity of Michigan Medical School, Ann Arbor
The advantages, disadvantage pitfalls, and rational approach biophysical techniques for the assessment of fetal well-being be discussed.

Continued on next pa

Jess G. Thoene, MD

J. Robert Willson, MD

James P. Woods, Jr., MD

Hermann A. Ziel, Jr., MD

“Maternal/Perinatal Health: A Delicate Balance”

Thursday afternoon, March 21

URSDAY LUNCHEONS/
ntinued

actical Office Sonography"
hard Bowerman, MD, Assis-
t Professor of Radiology, Uni-
sity of Michigan Medical
hool, Ann Arbor
ile sonography in the obstetric
l gynecologic office setting is
formed with increasing fre-
ency, physicians' sonographic
ls may need refinement. Per-
ent sonographic principles and
outline of ultrasound exami-
ions will be presented.

rsing Liability in the
inatal Period"
erly J. Hires, RN, JD, Som-
rs, Schwartz, Silver &
wartz, P.C., Southfield
sing negligence resulting in
ry to the patient and liability
inst the hospital can lead to
sible litigation. The role of the
fessional nurse and the im-
tance of charting, monitoring
documentation as deterrents
malpractice charges against
sicians and hospitals will be
ussed. The nurse practice act
requirements of other reg-
ory agencies and associations
be included.

n the Horizon"

derator: Steven M. Donn,
, Associate Professor of
liatrics, Section of Newborn
vices, University of Michigan
dical Center, Ann Arbor

5 to 2:05
olecular Genetics"
nald Rucknagel, MD, PhD,
fessor and Acting Chairman,
artment of Human Genetics
Professor, Department of Internal Medicine, University of Michigan, Medical School, Ann Arbor
The ability to clone single human genes into bacteria allows construction of large amounts of radioactive probes for specific DNA sequences. Although remarkable detail on gene structure and function is emerging from their use, the most immediate payoff is its use for prenatal diagnosis of inherited diseases.

2:05 to 2:25
"Artificial Surfactant Therapy in Neonatal RDS"
Robert E. Schumacher, MD, Instructor, Department of Pediatrics and Communicable Diseases, Section of Newborn Services, University of Michigan Medical Center, Ann Arbor
Early reports on the use of artificial surfactant in neonatal RDS were encouraging, but study design and potential adverse side effects raised concerns. A number of clinical trials of the use of surfactant are underway. This presentation will update the current status of surfactant therapy in RDS.

2:25 to 2:45
"Catastrophic Inborn Errors of Metabolism in the Newborn"
Jess G. Thoene, MD, Associate Professor, Department of Pediatrics and Assistant Professor of Biological Chemistry, University of Michigan Medical School, Ann Arbor
Certain inborn errors of metabolism present as overwhelming illness in the neonatal period. Rapid diagnosis may permit life-saving intervention with specific therapy. Example of vitamin-responsive organic acidemias and urea cycle defects will be presented.

2:45 to 3:05
"High Frequency Ventilation"
Joseph R. Custer, MD, Director, Pediatric Intensive Care Unit, C. S. Mott Children's Hospital, Ann Arbor
High frequency ventilation, a 15-year-old modality, encompassing the techniques of oscillation, flow-interruption, or jet ventilation has been recently applied to neonatal respiratory disorders. Increased understanding of the mechanisms of this technique may allow physicians to employ high frequency ventilation where likely to be useful.

3:05 to 3:25
"Chorionic Villi Sampling"
Federico G. Mariona, MD, Associate Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit
Perinatal diagnosis is an integral part of obstetrical care. Transcervical aspiration of villi in the first trimester may offer distinct advantages over the traditional amniocentesis.

3:25 to 3:45
"Laboratory Diagnosis of Obstetric and Gynecologic Infections: An Update"
John H. Grossman, III, MD, PhD, FACOG, Associate Professor of Obstetrics and Gynecology, and Microbiology; Director, Division of Maternal-Fetal Medicine, The George Washington University School of Medicine and Health Sciences, Washington, DC
New diagnostic tests allow for safe and effective clinical application by health care practitioners in management of obstetric and gynecologic infections. The "state of the art" will be defined.

3:45 to 4:15
Panel Question and Answer Session:
Doctors Custer, Grossman, Mariona, Rucknagel, Schumacher, and Thoene

4:15
Conference Adjourns

24th Annual Michigan Conference on Maternal and Perinatal Health

"Maternal/Perinatal Health: A Delicate Balance"

March 20-21, 1985 Hyatt Regency Dearborn

Wednesday, March 20

7:30 a.m.	Registration
8:15 a.m.	Welcome
8:30 a.m.	"The Nurse/Physician Relationship"
9:15 a.m.	"Perinatal Loss — A Multidisciplinary Approach"
10:00 a.m.	Q & A Session
10:15 a.m.	Break
10:45 a.m.	"Management of Post-Partum Bleeding"
11:45 a.m.	Q & A Session
12:00 Noon	Adjourn to Luncheon Meetings

Wednesday afternoon: "Care of the Very Low Birthweight Infant"

1:45 p.m.	"Obstetrical Aspects"
2:30 p.m.	"Nursing Aspects"
3:15 p.m.	Break
3:45 p.m.	"Neonatal Aspects"
4:30 p.m.	Panel Q & A Session
5:00 p.m.	Adjournment

Thursday, March 21

7:30 a.m.	Registration
8:15 a.m.	"In-Vitro Fertilization"
9:15 a.m.	"Sexually-Transmitted Disease in Pregnancy"
10:15 a.m.	Break
10:45 a.m.	"Malpractice in Obstetrics — Leg Aspects"
11:30 a.m.	Q & A Session
12:00 Noon	Adjourn to Luncheon Meetings

Thursday afternoon: "On the Horizon"

1:45 p.m.	"Molecular Genetics"
2:05 p.m.	"Artificial Surfactant Therapy in Neonatal RDS"
2:25 p.m.	"Catastrophic Inborn Errors of Metabolism in the Newborn"
2:45 p.m.	"High Frequency Ventilation"
3:05 p.m.	"Chorionic Villi Sampling"
3:25 p.m.	"Laboratory Diagnosis of Ob-Gyn Infections: An Update"
3:45 p.m.	Panel Q & A Session
4:15 p.m.	Conference Adjourns

Advance Registration For Michigan Conference on Maternal and Perinatal Health

Name ______________________________
(Please Print) (first) (initial) (last)
Address ______________________________
City, State ______________ Zip ________ Phone ______________
MSMS Member: Yes ______ No ______
Nurse ______ Resident ______ Other ______________

Tuition Schedule

Physicians: $35 each General Sessio
Nurses: $20 each General Session
Others: $20 each General Session
Residents & Students: No Charge f
General Session
Luncheon: $10 for All Registrants

Wednesday, March 20, 1985

☐ General Session $ ______
☐ Luncheon Meetings (indicate 1st & 2nd choices): $ ______
- ______ Ethics/Malformed Fetus
- ______ Prolonged Pregnancy
- ______ Neonatal Nursing
- ______ Addicted Fetus/Newborn
- ______ OB Nurse Practitioner

Wednesday Total = $ ______

Thursday, March 21, 1985

☐ General Session $ ______
☐ Luncheon Meetings (indicate 1st & 2nd choices): $ ______
- ______ Dermatologic Problems
- ______ Ethics/Handicapped Newborn
- ______ Fetal Well-Being
- ______ Office Sonography
- ______ Nursing Liability

Thursday Total = $ ______

Checks payable to **Michigan State Medical Society**

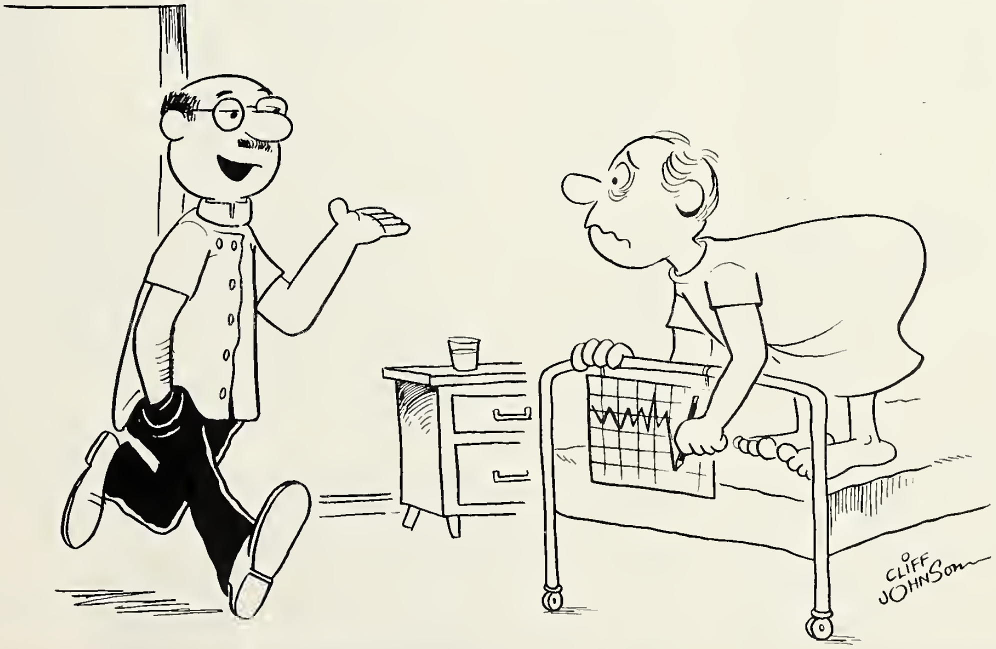
GRAND TOTAL $ ______

Please complete and mail with your check to MSMS, P.O. Box 950, East Lansing, MI 48823, (517/337-1351) Confirmati of your registration will be sent to you with a hotel reservation card.

These AMA scientific reports available to members

SMS has copies of the following general-interest reports adopted the 1984 AMA Interim House of Delegates in their Dec. 2-5 meet- g in Honolulu. The reports listed here are available by contacting urie Swick at MSMS headquarters, 120 W. Saginaw St., East Lansing, 823, 517/337-1351.

port: A Saccharin and Aspar- tme: Review of Safety Issues
port: B Guidelines for Report- g Estimates of Probability of ternity
port: C Effects of Toxic Chemi- cls on the Reproductive Cycle
port: D Guidelines for Han- ng Parenteral Antineoplastics esolution 104, I-83)
port: E SI Units for Clinical boratory Data
port: F Chelation Therapy
port: G Polygraphy (Resolution , A-83)
port: H Nicotine Chewing Gum for Cessation for Smoking
Report: I AMA Diagnostic and Treatment Guidelines on Child Abuse and Neglect
Report: J Current Status of Therapeutic Plasmapheresis and Related Techniques: Report of the AMA Panel on Therapeutic Plasmapheresis
Report: K Scientific Status of Refreshing Recollection by the Use of Hypnosis
Report: L The Health Effects of "Agent Orange" and Polychlorinated Dioxin Contaminants: An Update, 1984



"Come, come, Mr. Walters . . . We'll be the judge of that!"

Doctor Berglund warns members of union pitfalls

The Michigan State Medical Society has no relationship with the Union of Michigan Physicians and Dentists and the union is not a part, directly or indirectly, of MSMS, Thomas R. Berglund, MD, Chairman of the MSMS Board of Directors, has announced.

"At no time in the development of the union has MSMS or any of its component societies assisted, encouraged or guided its activities. In fact, we have discouraged our members from taking part in the union, based on anti-trust statutes and the Federal Trade Commission Order of 1983, that clearly delineates the parameters of activity of a professional association," Doctor Berglund said.

Doctor Berglund's declaration is founded on a legal opinion by Kerr, Russell & Weber, MSMS legal counsel.

MSMS and all Michigan physicians understand the problems and frustrations that gave birth to this "union." But the solutions, if any, are not found in a legally impermissible group action.

MSMS is anxious to protect its members from exposing themselves to what may be anti-trust action if the union bands together to attempt to influence fee structures, Doctor Berglund said. "Joining together to affect fees is a violation of the anti-trust laws. It is incumbent, therefore, that we alert MSMS members to the dangers of participating in so called union activity, and make it known to all that the union and MSMS have no connections whatever."

The following is an abstract from the legal opinion prepared by Richard D. Weber:

The overriding design and purpose of organizing the Union of Michigan Physicians and Dentists is "predicated on the need for collective bargaining." This position is emphasized by the union's ultimatum that "unless there is an agreement signed between the doctors and a fiscal intermediary, no third-party carrier shall determine doctors' fees unilaterally."

In 1975 the Supreme Court determined that the "learned professions" and their organized associations were not exempt from scrutiny under the Sherman anti-trust laws (Goldfarb v Virginia State Bar.) The Court held that a bar association's rule prescribing minimum fees for legal services restrained trade by engaging in "price-fixing" activities in violation of the Sherman Act.

In 1978 the Court expanded on the Goldfarb decision when it invalidated the National Society of Professional Engineer's code of ethics which prohibited professional engineers from discussing prices with potential customers until after negotiations had resulted in the initial selection of an engineer. (National Society of Professional Engineers vs. United States). That decision paved the way for the courts to apply the "per se" analysis to any price-fixing agreements regardless of whether those agreements are in a unique industry and can be reasonably justified. The implications of this ruling are that anti-trust doctrines developed in the context of pricing behavior will be held to apply to professional fee-related conduct with little or no exception.

Any combination of competitors having the purpose or effect of raising, depressing, pegging, fixing or stabilizing prices may be condemned as price-fixing.

In 1982 the Supreme Court decided an anti-trust price-fixing issue involving the health care industry. In Arizona v Maricopa County Medical Society, the Court found that a medical society's schedule of maximum fees that participating physicians agreed to accept as payment in full for services performed for patients insured under plans approved by the society was a pe se illegal price-fixing activity in violation of the anti-trust laws.

The court's decision in Maricopa announces the prese position that any combination o independent competing individuals, whether professionals o otherwise, who collectively act to interfere with competitive pricing in the marketplace will be subject to liability.

The FTC's recent attacks on th AMA and MSMS further highlig the illegality of collective bargaining among physicians. In th AMA decision, the courts affirmed the FTC's ruling that the AMA and other state and local medical societies could not concertedly place restraints on physician advertising and pricing practices.

In the MSMS litigation with th FTC, the FTC ruled that the at-

Continued on page 2

Doctor Berglund, Portage, is chairman, MSMS Board of Directors.

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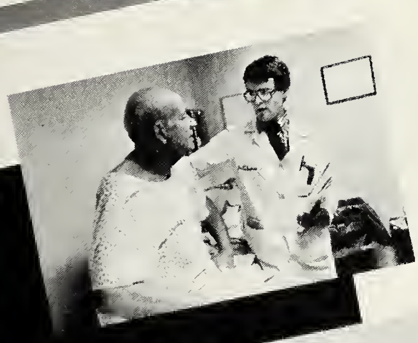

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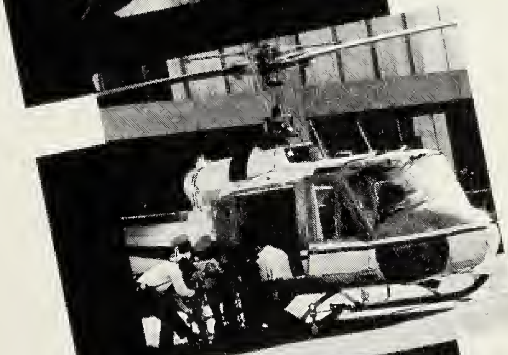

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DISCLAIMER/continued

tempts of MSMS to act as the "exclusive bargaining agent" of physician members in order to negotiate the manner by which fees or reimbursement levels would be established was an unlawful restraint of trade. Despite the fact that MSMS was merely attempting to influence the methods by which BCBSM calculates its reimbursement schedule, the FTC did not feel that this indirect method of collective pricing activity was any less illegal.

With regard to organized labor's exemption from anti-trust, the opinion states that Congress has enacted various provisions in order to immunize labor union activities from challenges under the Sherman Act. Interpretations of the legislation hold that the exemption applies only to union activities directed against an employer by its employees. The courts further have held that when independent individual entrepreneurs organize into a group, whether identified as a labor group or not, they may not trigger the statutory labor exemption. It is possible that in situations where a physician is salaried and strictly under the fulltime employment of a health care facility (e.g., HMO or employed hospital staff) the physicians within that facility could collectively bargain for salary reimbursement rates. This type of collective bargaining is but a small part of what the union states it will undertake.

In summary the legal opinion says that activities of organized physicians which affect reimbursement fees or policies of third party carriers will be subject to careful scrutiny under the anti-trust laws. Collective bargaining for physician reimbursement rates on behalf of independently practicing physicians is considered horizontal price-fixing among competitors in the health care market, and therefore, a per se illegal restraint of trade.

The opinion then concludes: "The thrust of the union's objective to "Collectively bargain" with third-party carriers on behalf of private practitioners would involve activities which face significant anti-trust impediments. Independent practicing physicians (considered direct competitors in the health care industry) who organize and allow the union to collectively bargain reimbursement rates with third-party payors on their behalf engage in violations of the anti-trust laws."

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Michael A. Epstein (Student)
6430 Pinecroft
West Bloomfield 48033

Gregory M. Oldford (Student)
3525 Maxwell Ct.
Birmingham 48010

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Flint 48509

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Pontiac 48053

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St. Clair Shores 48081

Dhafer S. Salama, MD — OTO/NS
11012 E. 12 Mile Rd. #205
Warren 48093

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Detroit 48235

Ravindra R. Sharma, MD — EM
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Southfield 48034

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Madison Heights 48071

Janusz J. Zielinski, MD — P/N
3800 Woodward Ave.
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By Kristine Portnoy

Medical news reporting: both sides of the story

Stan Soffin, PhD, MSU School of Journalism chairman, holds the microphone during an interview with Louis Zako, MD, MSMS president. Two journalism students listen in. *Photo by Mike Kitchen.*

Medical and science news reporting is a skill that requires objectivity and skepticism, said reporters and physicians at a November medical news reporting seminar co-sponsored by MSU's school of Journalism and Michigan State Medical Society.

Stan Soffin, PhD, chairman of the School of Journalism, opened the seminar attended by more than 300 journalism and communications students.

Ben Burns, executive editor of the *Detroit News* spoke on the importace of medical news and said the best medical/science writers can translate the language of science into the language of the reader.

"A good medical writer takes years to develop," Burns said.

Most large daily newspapers have medical/science writers that can and will do a good job on medical reporting, Burns said.

Mistakes in medical reports usually are the fault of the editor who is trying to put "zip" into the story, he said.

Following Burns was MSMS president Louis R. Zako, MD, Dearborn Heights, who discussed what he sees as today's medical issues.

The cost of health care is an issue of importance, Zako said, but the cost is relative to the other products and services people may buy instead of health care.

Zako said the health care costs have been blown out of proportion by the press, and that the press tends to sensationalize medical news. He cited the case of "Baby Fae," the infant that received national attention for a baboon heart transplant.

More reporting should be done on issues such as the plight of Medicare, he said.

"I think Medicare is in serious trouble and I'm concerned about it," Zako said. "I don't think a person should be denied health care just because he's poor."

Zako said the media should report on potential answers to the problems of rising health costs and Medicare, not simply report the fact that problems do exist.

But, Zako did say medical reporting in Michigan, despite these criticisms, is "unusually good."

Zako's speech was followed by a panel discussion on reporting problems, moderated by Bruce Ambrose, MSMS executive director.

Panelist Dolly Katz, medical writer for the *Detroit Free Press*, responded to Zako's comments by saying some physicians emphasize sensational facts at press conferences. Katz said reporters must resist the sensationalism emitted from the medical profession by being skeptical.

Another panelist, Arnold Werner, MD, a broadcaster and faculty member at MSU's Department of Psychiatry said writers face numerous problems in medical reporting.

Three problems reporters must be aware of are the voyeuristic tendencies of the public, the ethics involved in both journalism and medicine and the sensitivity of the sources who may be affected by the reported medical problem, he said.

Millicent Lane, staff writer for the *Lansing State Journal* said she agreed that reporters must be careful of getting caught up in the enthusiasm of the scientist.☐

Ms. Portnoy is a junior at MSU's School of Journalism.

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By William E. Powers, MD

Detroit's superconducting cyclotron will be a first for radiation therapy

Radiation therapy available to cancer patients in Michigan will have an additional modality with the new neutron therapy unit to be installed in the Radiation Oncology Center of Harper Hospital in approximately two years. Harper Hospital will be the first in the world to have a compact superconducting cyclotron designed specifically for hospital use to produce neutrons for radiation therapy. The project is a joint venture of Michigan State University and Harper Hospital.

The unit, designed by Henry G. Blosser, MD, director of the National Superconducting Cyclotron Laboratory at MSU, is based on the technology developed in recent years at that laboratory and successfully applied to the construction of powerful superconducting cyclotrons for nuclear physics research. Utilizing a superconducting magnet in the design of this medical cyclotron permits a significant reduction in both the size and cost of the unit and the facility when compared with conventional cyclotrons. These reductions are due to the increased power of the small magnet and the internal target which obviates a beam transport system and thus a separate treatment head.

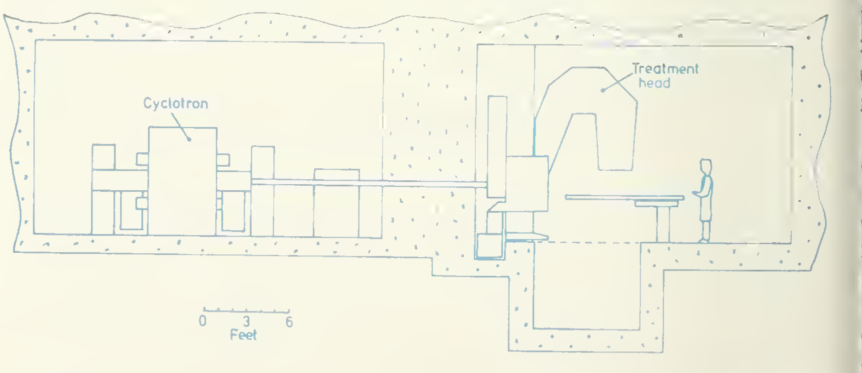
The unit compares to a conventional high energy photon radiation therapy accelerator in its initial cost, the shielded space required to house the unit and the personnel to operate the facility. This new cyclotron will have the flexibility and beam characteristics of a 6 MEV accelerator but with the biological advantages of neutrons.

Neutron advantages

Neutron therapy has been shown to be of particular benefit to a number of patients with moderately- to far-advanced as well as inoperable or recurrent tumors of the head and neck area (especially salivary gland tumors), soft tissue sarcomas and primary bone tumors, and tumors of the genitourinary system (prostate, bladder and cervix).

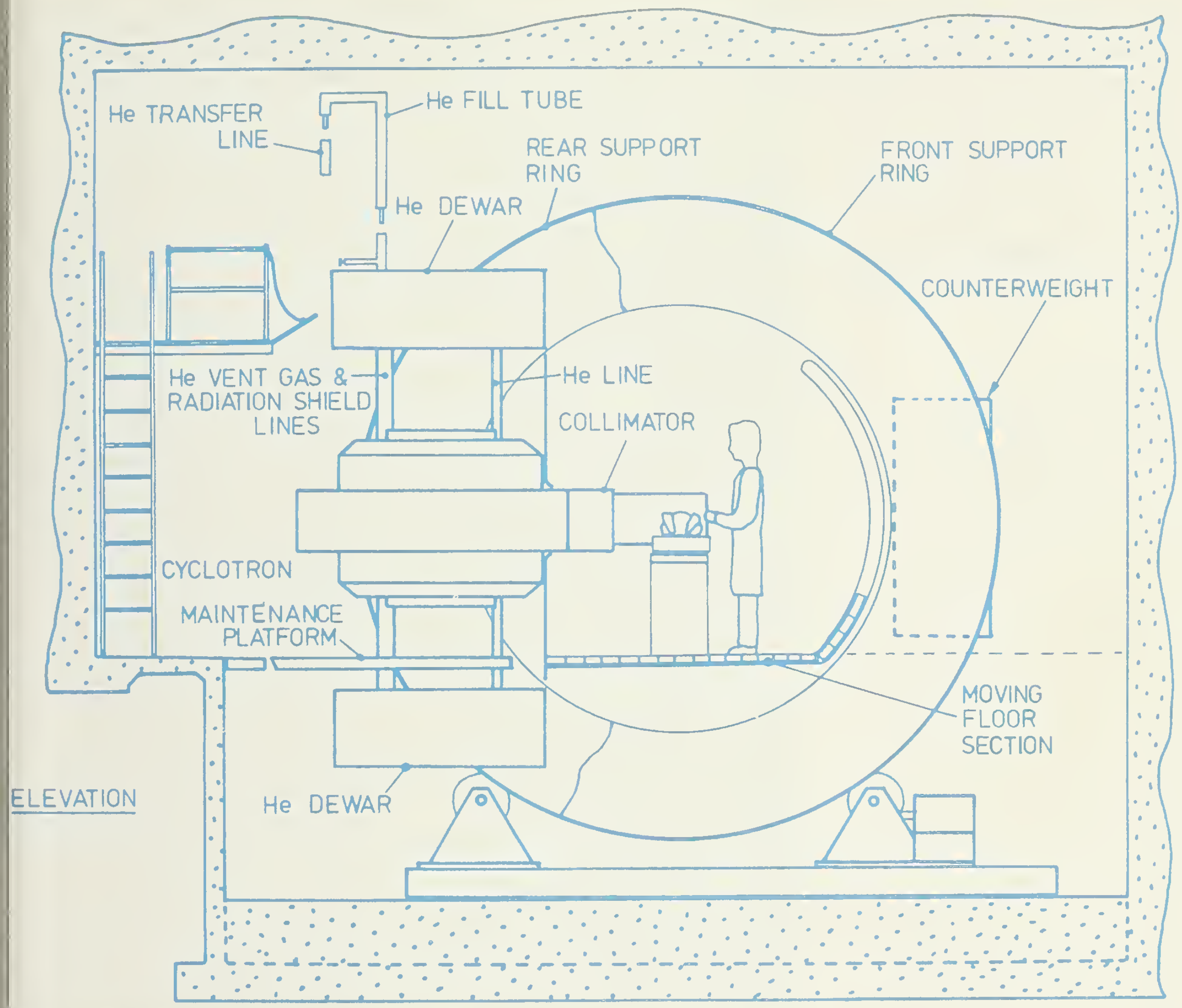
While conventional radiation therapy is successful in the treatment of many of these patients, more advanced tumors are often resistant. Trials around the world using conversions of nuclear physics machines have shown these resistant tumors to be more responsive to neutron treatments than to conventional radiation therapy with the usual tolerable doses. This benefit has been observed in spite of the primitive facilities usually associated with a modified physics machine.

The failure of conventional radiation therapy in the treatment of resistant tumors may be attributed to two major problems, both of which are overcome by the use of neutron therapy. One problem is the existence of hypoxic cells within the tumor. These are cells with lower than normal oxygen tension which occur in areas of the tumor that are beyond the normal range of oxygen perfusion. Apparently



A conventional cyclotron with an isocentric treatment head for neutron radiation therapy. The installation requires two shielded rooms.

Doctor Powers is director, Radiation Oncology Center, Harper Hospital, and professor and chairman of radiation oncology at Wayne State University.


He TRANSFER LINE
He FILL TUBE
REAR SUPPORT RING
FRONT SUPPORT RING
He DEWAR
COUNTERWEIGHT
He VENT GAS & RADIATION SHIELD LINES
He LINE
COLLIMATOR
CYCLOTRON
MAINTENANCE PLATFORM
MOVING FLOOR SECTION
ELEVATION
He DEWAR

superconducting cyclotron installed in a single room for neutron radiation erapy.

mor cells can survive in a
poxic state and have increased
sistance to usual ionizing radi-
on as compared to well oxyge-
ted cells. That some of these
mor cells survive the usual
ses of radiation (limited in all
ses by radiation tolerance of
rmal well oxygenated tissues
the region) is considered the
ajor cause of local failure. The
sponse of hypoxic cells to neut-
n irradiation is closer to that of
rmal well oxygenated cells and
nce there is more likelihood
killing these hypoxic resistant
mor cells (and curing the
mor) with doses tolerable to
e surrounding normal tissues.

The second reason for treatment failure is the capacity inherent within some tumor cells to repair sublethal doses of radiation in the interval between the fractions of radiation therapy. This capacity is reduced with the use of neutron irradiation since the sublethal component of the neutron dose effect is less.

Reduced treatment time

Conventional radiation therapy is protracted and fractionated in order to achieve: a) healing of normal tissues in the intervals; and b) reoxygenation of tumor cells which tends to reduce the hypoxia in the tumor and thus reduce resistance. Since neutron therapy is less dependent on the oxygen tension of the cells and/or their repair capacity than conventional radiation therapy it is also less dependent on the overall treatment time and number of fractions. Curative neutron therapy may be delivered in 15 fractions over a four week period compared to the conventional treatment regimen of 30 to 40 fractions in 6 to 7½ weeks. This may lead to a significant reduction in the overall cost of treatment.

We expect that tumors that are relatively slow growing and have resistance due either to tumor

Continued on page 36

CYCLOTRON/continued

cell environment or inherent resistance will be the primary candidates for this treatment. As in all radiation therapy it is necessary for preservation of sufficient matrix tissue and normal cells within the high dose volume to allow healing and reconstitution of the organs and tissues following treatment. Hence patients with massive destruction of normal tissues are not suitable for curative treatment.

Higher cure rate

Radiation therapy with neutrons is expected to increase the cure rate of resistant tumors while preserving function and to improve the palliation of patients with tumors too far advanced for cure such as bone metastases.

At the present time, clinical trials of neutron therapy are being supported by the National Cancer Institute at a number of neutron therapy facilities. Several of these centers have installed hospital-based, conventional room temperature cyclotrons. Funding of $4 million per year is available for clinical trials and Harper Hospital expects to be part of this program and thus to contribute to the demonstration of the clinical benefits of neutron therapy.

We propose to invite participation by and collaboration with all radiation therapists and physicists in Michigan. Participation will include: a) setting priority of patients and tumor types to be treated; b) decision about applicability of neutron therapy for a particular patient; and c) involvement in the care of each treated patient.

We estimate that in Michigan approximately 4,000 patients die each year because of uncontrolled local and regional tumor and that a significant fraction of these patients can be identified as candidates for neutron therapy or other treatment strategy that reduces the resistance of the tumor cells to radiation treatments. While not all of these patients will be candidates for neutron therapy we expect to cure many patients who now fail.□

Drug information program

The American Academy of Family Physicians has developed an updated consumer prescription drug information program. Drug Use Education Tips (DUET) is designed to aid physicians in educating patients about prescription medications.

A cooperative effort between the AAFP and the United States Pharmacopeial Convention Inc. (USP), DUET consists of sets of 290 monograph abstraction from the 1984 USP publication *Advice for the Patient.* The DUET system also includes suggestions for using the materials in the family doctor's office and a poster urging patients to "Ask About Your Medicine."

The price of the DUET system is $10. For more information, contact AAFP's Washington Office, 600 Maryland Ave., S.W., Suite 770, Washington, D.C. 20024, or telephone (202) 488-7448.

Psoriasis, acne, eczema patients sought

The University of Michigan Department of Dermatology is seeking volunteers with psoriasis, acne, or eczema to participate in research studies which assess the efficacy of new therapies. Several studies using either topical or oral medications are available at no charge to subjects who qualify. Further information may be obtained by calling the Clinical Pharmacology Unit at (313) 763-5519.

Bladder cancer detection

A research team at the Litton Institute of Applied Biotechnology (LIAB) and The University of Texas Health Center in San Antonio has developed a sensitive and specific immunoassay procedure using a monoclonal antibody to identify and monitor a bladder cancer marker in urine. This new rapid identification procedure has potential both in early diagnosis of bladder cancer and in monitoring patients following surgery of the primary tumor. The monoclonal antibody used in the assay has a high affinity for fibrinogen. Fibrinogen and fibrin degradation products, found in the urine of bladder cancer patients, are reliable markers of the disease.

The immunoassay takes only a few hours to complete and is less expensive, more objective, and more accurate than other methods, according to the American Association for Cancer Research. The researchers performed the assay on a random panel of 412 urine samples from 108 patients and it was found to be both highly specific and sensitive. It accurately identified 83% of the urine specimens for the cancer, and it is so specific that it had an overall accuracy of 80% for all specimens, including patients that were bladder tumor negative.

Sex counseling guide

"Sexual Problems in Medical Practice" is the title of an AMA guide to help physicians with little or no background in sexual counseling. Each of the 27 chapters is written by an authority in the field of human sexuality. Harold L. Lief, MD, is editor-in-chief. Price is $24 for nonmember physicians and $12 for medical students. AMA members receive a 10% discount. To order, write AMA Order Handling Fulfillment Unit, OP-120, P.O. Box 10946, Chicago, Ill. 60610.

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and your
New Year be
prosperous.

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Our 1984 Annual Scientific Meeting

The registration area was bustling with activity at the opening of the 1984 Annual Scientific Meeting as participants checked in and checked out the exhibits.

Physicians earned up to 18 Category I credits during the three-day meeting at the Hyatt Regency Dearborn

Samuel M. McMahon, MD, chairman of the MSMS CME Programming Cor mittee, left, talked with MSMS Executive Director Bruce W. Ambrose over cup of coffee in the Annual Scientific Meeting faculty headquarters.

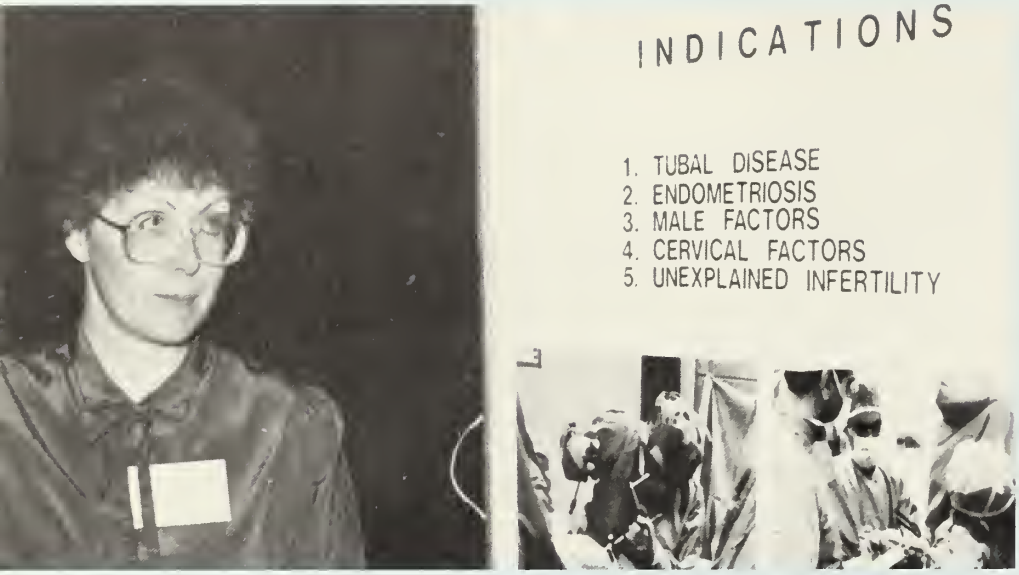
Photos by:
Rod Reiser,
Detroit

DEARBORN
SWANS
GORSK

ore than 1,200 physicians signed up for 55 courses offered during the
ree-day meeting in Dearborn. Just one of those courses, "What's New
Dermatology" is pictured above.

ore photo highlights
n page 40.

MSMS President Louis R. Zako, MD, right, attended several courses throughout the meeting. Richard J. Potter, MD, West Branch, is pictured on the left.



INDICATIONS

1. TUBAL DISEASE
2. ENDOMETRIOSIS
3. MALE FACTORS
4. CERVICAL FACTORS
5. UNEXPLAINED INFERTILITY

Patricia A. Rogus, BSN, RN studied a poster display titled, "Clinical Experiences with In-Vitro Fertilization and Embryo Transfer," which was prepared by Maria Ferraro Hayes, MD.

David R. Rovner, MD, right, 1983-84 chairman of the MSMS Annual Scientific Meeting Planning Committee congratulates C. Edward Cotton, MD, on being named 1985-86 chairman. Doctor Cotton is president of the Michigan Academy of Family Physicians.

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

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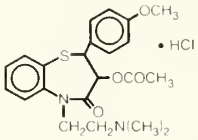
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis- The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks)
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (
asthenia (1.2%), AV block (1.1%). In addition, the following
were reported infrequently (less than 1%) with the order of pre
tion corresponding to the relative frequency of occurrence.

Cardiovascular.	Flushing, arrhythmia, hypotension, bra dia, palpitations, congestive heart f syncope.
Nervous System	Paresthesia, nervousness, somnol tremor, insomnia, hallucinations, and am
Gastrointestinal	Constipation, dyspepsia, diarrhea, vo mild elevations of alkaline phosphatase, SGPT, and LDH
Dermatologic:	Pruritus, petechiae, urticaria, photosens
Other:	Polyuria, nocturia

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episo
vasospastic angina developed periods of transient asympt
asystole approximately five hours after receiving a single
dose of CARDIZEM.

The following postmarketing events have been reported
quently in patients receiving CARDIZEM. erythema multiform
kopenia; and extreme elevations of alkaline phosphatase,
SGPT, LDH, and CPK. However, a definitive cause and effect be
these events and CARDIZEM therapy is yet to be establishe

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been li
Single oral doses of 300 mg of CARDIZEM have been well tol
by healthy volunteers. In the event of overdosage or exagg
response, appropriate supportive measures should be emplo
addition to gastric lavage. The following measures may be consi

Bradycardia	Administer atropine (0.60 to 1.0 mg). I is no response to vagal blockade, adm isoproterenol cautiously
High-Degree AV Block	Treat as for bradycardia above. Fixed degree AV block should be treated wi diac pacing.
Cardiac Failure	Administer inotropic agents (isoprote dopamine, or dobutamine) and diuretics
Hypotension	Vasopressors (eg, dopamine or levart bitartrate).

Actual treatment and dosage should depend on the severity
clinical situation and the judgment and experience of the t
physician.

The oral/LD_{50}'s in mice and rats range from 415 to 7[illegible]
and from 560 to 810 mg/kg, respectively. The intravenous LD
these species were 60 and 38 mg/kg, respectively The oral L
dogs is considered to be in excess of 50 mg/kg, while lethali
seen in monkeys at 360 mg/kg. The toxic dose in man is not
but blood levels in excess of 800 ng/ml have not been asso
with toxicity.

DOSAGE AND ADMINISTRATION

**Exertional Angina Pectoris Due to Atherosclerotic
nary Artery Disease or Angina Pectoris at Rest Due to
nary Artery Spasm.** Dosage must be adjusted to each pa
needs. Starting with 30 mg four times daily, before meals
bedtime, dosage should be increased gradually (given in
doses three or four times daily) at one- to two-day interval
optimum response is obtained. Although individual patient
respond to any dosage level, the average optimum dosage
appears to be 180 to 240 mg/day There are no available data c
ing dosage requirements in patients with impaired renal or
function. If the drug must be used in such patients, titration sh
carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort anginal attacks during CARDIZEM therapy
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be
coadministered with short- and long-acting nitrates, bu
have been no controlled studies to evaluate the anti
effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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0088-1771-47) and in Unit Dose Identification Paks of 10
0088-1771-49). Each green tablet is engraved with MARION
side and 1771 engraved on the other. CARDIZEM 60-mg
tablets are supplied in bottles of 100 (NDC 0088-1772-47) and
Dose Identification Paks of 100 (NDC 0088-1772-49). Each
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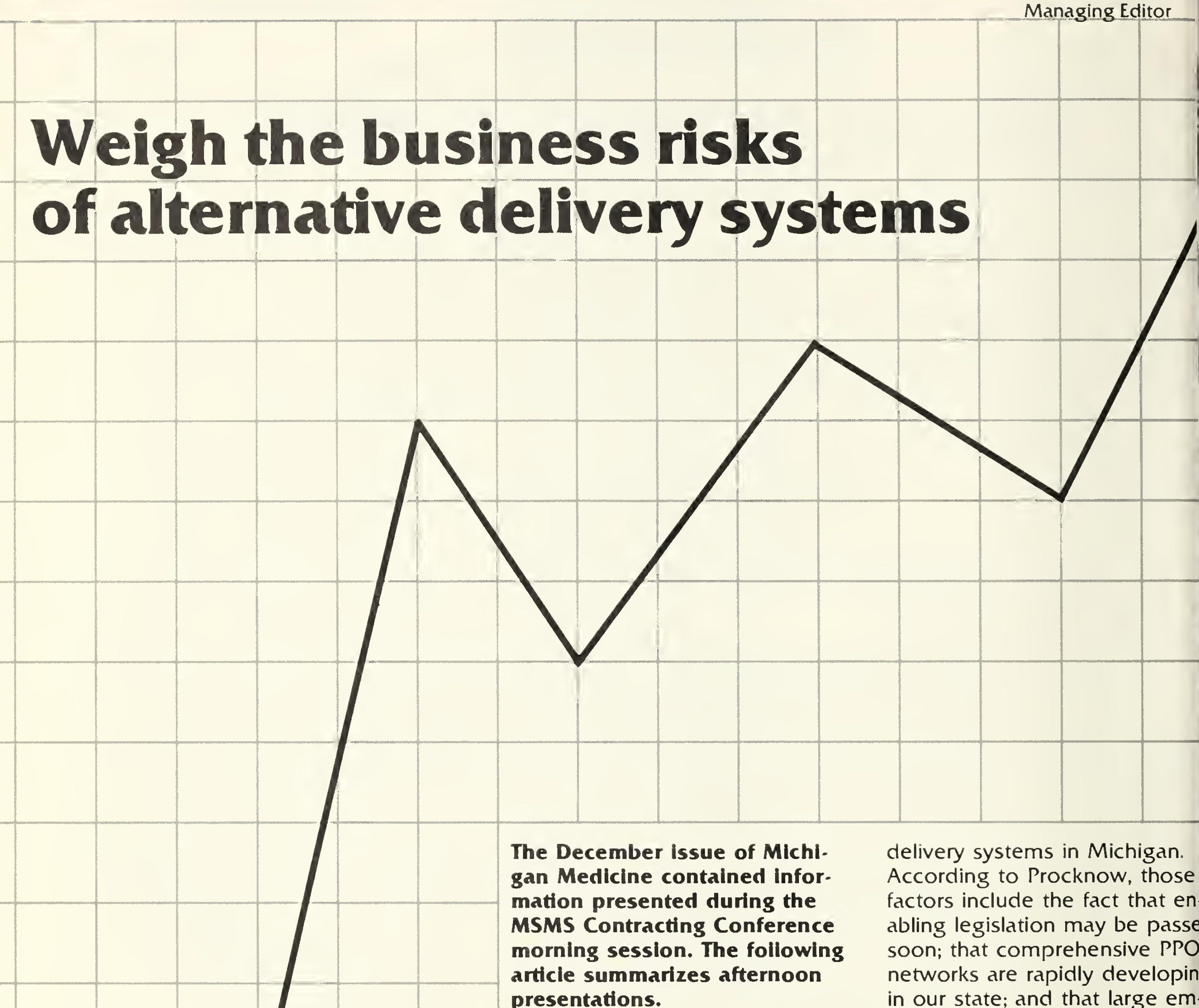

By Sheri W. Greenh
Managing Editor

Weigh the business risks of alternative delivery systems

The December issue of Michigan Medicine contained information presented during the MSMS Contracting Conference morning session. The following article summarizes afternoon presentations.

Deciding to participate in an alternative delivery system is an investment decision, and a physician must carefully weigh the benefits against the business risks. That was the message from Eugene Procknow, management consultant with Touche Ross & Company when he addressed more than 80 physicians at the MSMS Contracting Conference.

In order to make an informed decision, he said, physicians should seek professional assistance and research, research, research!

Some of the areas they should research are the major factors presently influencing alternative delivery systems in Michigan. According to Procknow, those factors include the fact that enabling legislation may be passe soon; that comprehensive PPO networks are rapidly developin in our state; and that large employers, more aware of rising health care costs, soon will spo sor both HMO and PPO programs.

Varying structures

Alternative delivery systems can take on many forms, and physicians thinking about enter ing into a contractual relationsh should study these varying stru tures. In general, there are four factors by which delivery syste are differentiated: sponsorship; marketing thrust; services provided; and plan design.

A system may be carrier-spo sored. This arrangement is simil to a fee-for-service IPA withou

Continued on page 4

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Please see following page for Brief Summary.

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TALWIN® Nx is intended for oral use only Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention, these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis

Precautions: *CNS Effect* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment In long-term use, precautions should be taken to avoid increases in dose by the patient *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting *Drug Interactions Usage with Alcohol* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed *Pregnancy Category C* Should be given to pregnant women only if clearly needed *Labor and Delivery* Use with caution in women delivering premature infants Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown *Nursing Mothers* Caution should be exercised when administered to a nursing woman *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope *Respiratory* Rarely, respiratory depression *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora *Ophthalmic* Visual blurring and focusing difficulty *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia *Other* Headache, chills, insomnia, weakness, urinary retention

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance

Dependence and withdrawal symptoms have been reported with orally administered pentazocine Patients with a history of drug dependence should be under close supervision Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx

The amount of naloxone present (0 5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine, however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated Assisted or controlled ventilation should also be considered For respiratory depression, parenteral naloxone is a specific and effective antagonist

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By Cathie L. Marti

Auxiliary focuses on perinatal care

The Michigan State Medical Society Auxiliary recognizes the importance of program coordination between itself and the Michigan State Medical Society Perhaps more than anywhere else this is evident in MSMS/A's efforts to provide educational materials and leadership in statewide health projects. Taking our lea from MSMS and the AMA, this year's Auxiliary Board of Directors is focusing its efforts on prenatal and post natal care issues.

Upon the 1983 recommendations of the Health Projects Committee, the Board purchased the film "One For My Baby", a documentary describing fetal alcohol syndrome (FAS), made and distributed by the March c Dimes. This 30 minute presentation is aimed at teens and adults. It combines research and statistics with a car did in-depth interview of a family learning to cope wit their child who suffers from FAS. Our health projects cc chairman, Dorothy Csonka has notified all county chair persons of the availability of this film. Already, Oaklanc and Washtenaw counties have used the movie extensively in area schools.

If you are interested in this film, contact your count auxiliary or write to Dorothy Csonka via MSMS/A office in East Lansing.

Remember, the state Auxiliary functions to support not just the spouse but also the physician by providin materials and information on health related topics. Yo interests are our interests - help us help you!☐

Mrs. Martin is president-elect of the MSMS Auxiliary.

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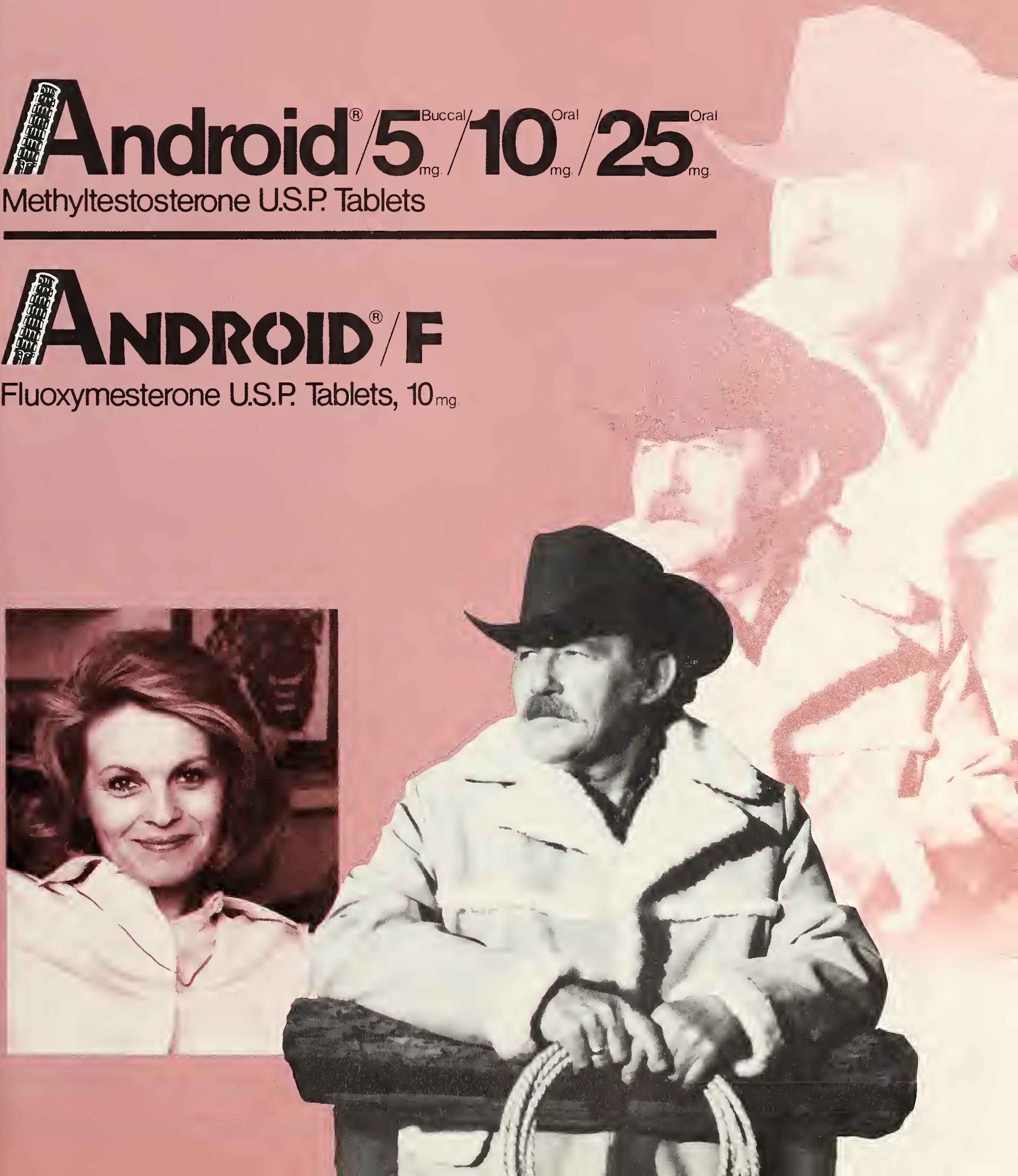
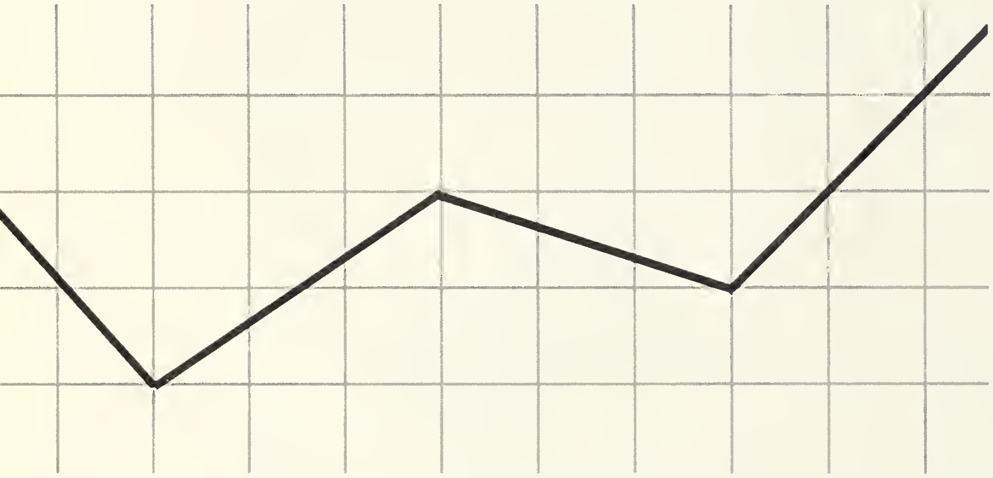


risk-sharing, and participation may be determined through a bidding process.

A provider-sponsored system could be hospital and/or physician sponsored, and involve multiple networks. This system typically is marketed to self-insured companies, and often is a separate corporation.

Employer-sponsored systems commonly are found in self-insured companies, and their primary objective is to lower costs. Participation in this system may be through bidding, also.

Marketing thrust is another factor to be considered when looking at alternative delivery systems. "Discount houses" offer fee-for-service discounts, but are not effective and will eventually perish, Procknow said. A systematic cost control structure offers discounts at the outset, but its main emphasis is on substantive cost control, not pricing strategies.



A third marketing thrust is on utilization review, wherein reduced utilization and ensured quality are the goals.

Other factors that must be studied before contracts are signed are the services provided, including health care services, administrative services, utilization review and reporting services, and third party administrator (TPA) services. TPA services often involve marketing and actuarial services which require much expertise, Procknow warned, and physicians must evaluate any provision of this nature carefully.

Risk-sharing

The goal of PPOs, Procknow reminded the audience, is to share risk with physicians. As PPOs evolve, he said, they begin to resemble HMOs in that they exercise stringent utilization control, limit freedom of choice, and have risk-sharing provisions.

Procknow pointed out that deciding whether to form or join a PPO depends on a lot of factors, including competition; the industry/business coalition climate; and excess capacity. But, he warned, the environment is constantly changing, and the best rule of thumb, in any case, is to diversify.

"Don't be afraid of it - be challenged by it," was the advice of Monte Jahnke, JD, of Kerr, Russell and Weber, MSMS legal counsel. Jahnke was referring to that changing practice environment, and predicted the medical profession will do well by it. He did, however, point out that the specifics of any particular contract should be carefully analyzed.

Contract features

Some contract features to be reviewed include: length of contract and terms of renewal; grounds for termination; contract amendment procedures; insurance coverage; degree of exclusivity; and licensing and regulation provisions.

Physicians need also to be apprised of any types of restrictions on patient care outlined in the contract. Are there established referral patterns? What hospitals or ancillary support services can be utilized? Does the contract stipulate any preadmission programs? What peer review guidelines or standards will be in effect?

Physicians must pay careful attention to contractual language and assure that they will be able to exercise reasonable medical judgement in treating patients.

Jahnke also emphasized that in the area of antitrust there are no easy answers. This is a complex and technical area of federal and state law. Too much caution cannot be exercised concerning such issues.

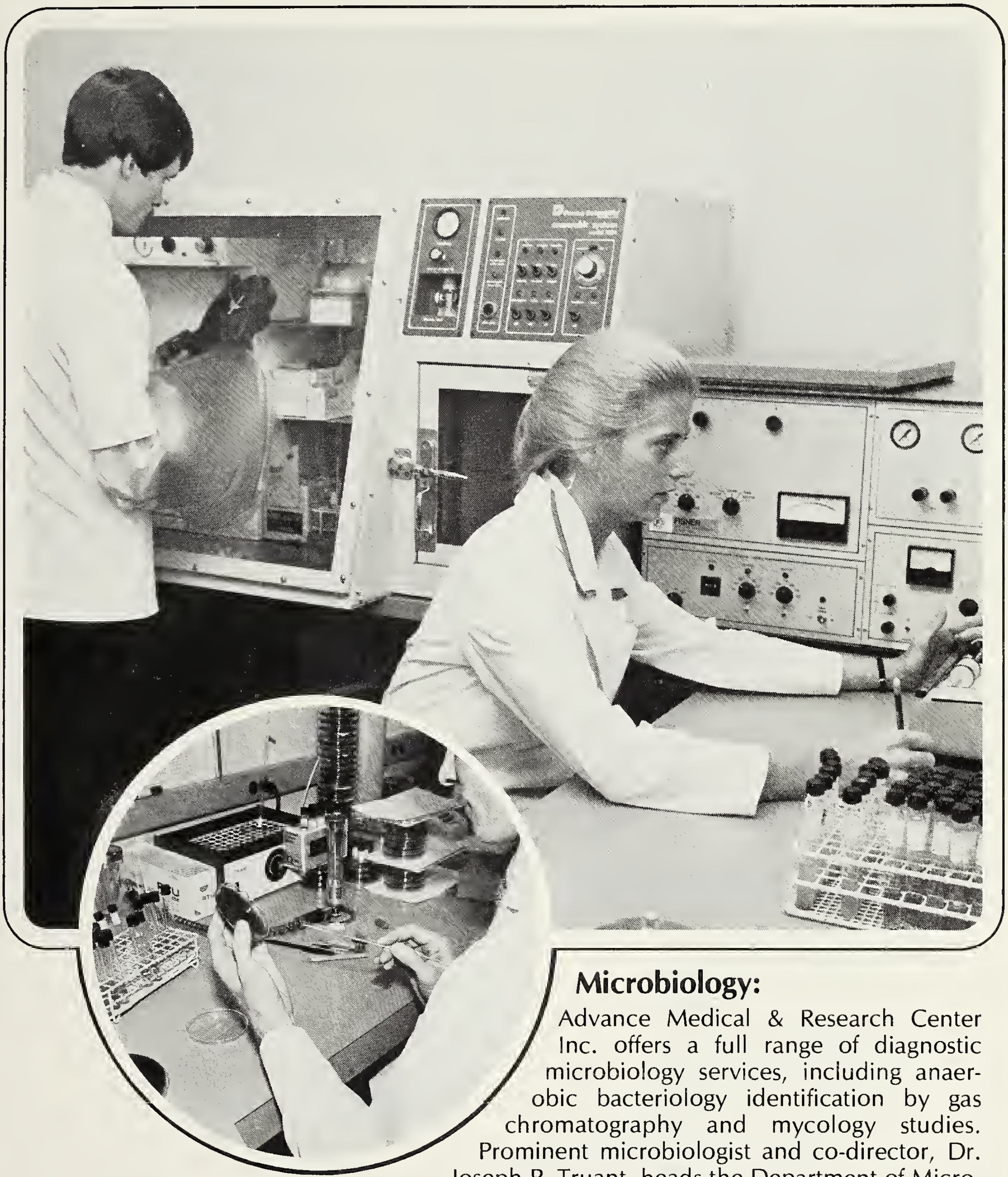
Joint ventures

Robert L. Weyhing, parter in the Detroit law firm of Clark, Klein and Beaumont discussed hospital/physician joint ventures from the hospital perspective. He acknowledged that hospitals and physicians share a mutual concern of delivering quality health care in an environment of cost containment. But, he said, current health care economics have threatened hospitals with sharp revenue losses and excess capacity due to declining use of inpatient services and shorter lengths of stay.

Part of the response of hospitals and physicians to these cost pressures is to form joint ventures of mutual benefit, Weyhing said. The joint ventures range in scope from real estate and other pure investment ventures to HMOs and PPOs.

Like the other speakers, he described the essentials of a sound contract, and went on to suggest optimum operational setups. He stressed, though, that no one factor was more important to the success of a joint venture than cooperation and trust.

Further information on contracting may be obtained from John Richards and Debbie Zanoth at MSMS headquarters.☐



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MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

February 4, (Feb. 11 Snow Day) — MSMS Auxiliary Board Meeting, MSMS Headquarters, East Lansing, contact: Viola Heins, MSMS headquarters.

February 8-10, — Medical Assistants Midwinter Seminar, Midway Motor Lodge, Warren, contact: Caroline Rich, MSMS headquarters.

February 14-16, — AMA National Leadership Conference, Palmer House, Chicago, contact: American Medical Association, 535 N. Dearborn St., Chicago, IL 60610 (312) 645-5000.

February 19-21, — AMA Auxiliary National Cluster Meeting, Drake Hotel, Chicago, contact: AMA, 535 N. Dearborn St., Chicago, IL 60610 (312) 645-5000.

February 21-23, — AMA Auxiliary Leadership Conference, Marriott Hotel, Chicago, contact AMA, 535 N. Dearborn St., Chicago, IL 60610 (312)645-5000.

February 27 — MSMS Committee on Membership Recruitment and Retention, MSMS headquarters, contact: Wayne Burmeister, MSMS headquarters.

March 6, — MSMS Board of Directors, MSMS headquarters, contact: William Madigan, MSMS headquarters.

March 11, — MSMS Hospital Medical Staff Section, Michigan Inn, Southfield, contact: Thomas E. White, MSMS headquarters.

March 12, — MSMS/A Legislative Day, Civic Center, Lansing, contact: Viola M. Heins, MSMS headquarters.

March 20-21, — Michigan Conference on Maternal and Perinata Health, Hyatt Regency Dearborn contact: Sherry L. Fent, MSMS headquarters.

April 26-28, — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contac Richard Campau, MSMS headquarters.

April 29, — MSMS/A Mini-Conference for County Officers, MSMS headquarters, East Lansing, contact: Viola Heins, MSM headquarters.

May 6-8, — 59th Annual Sessio MSMS Auxiliary, Holiday Inn, Muskegon, contact: Viola M Heins, MSMS headquarters.

June 16-20, — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 18-21 — Midsummer Meeting, MSMS Board of Directors, Hidden Valley, Gaylord, contact: William Madigan, MSMS headquarters.

OTHER MEETINGS

May 15 — Michigan Allergy Society Executive Committee Meeting, University of Michigan, contact: David Seaman, MD, Secretary, Michigan Allergy Society, 8578 Canton Center Road, Canton 48187 (313) 453-2661.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313) 839-3011.

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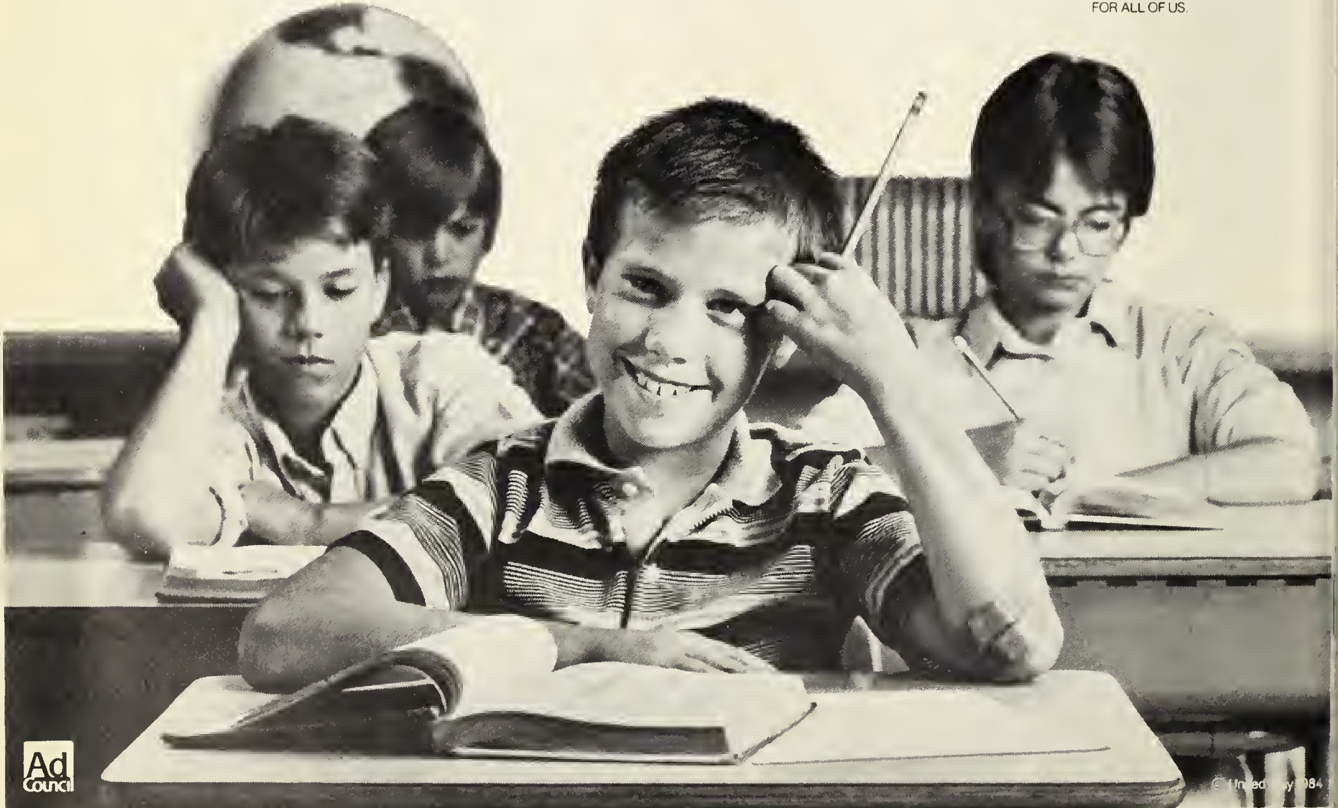

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— Since 1968 —

By Carole Eberl

Keeping patients at home a goal of British medicine

Cambridge, England — A commitment to keeping old people out of the hospital is what a Michigan State University physician is taking back to the US after a year of research and study at Cambridge University.

"This would involve a three part approach," said Sumer Verma, MD, at his office in Addenbrookes Hospital in this university city. "This would mean we would have to see if people can be treated at home, to keep people at home as long as possible and to provide relatives with a great deal of support.

"With all of that, I think we could begin to keep people out of the hospital," he said.

Home care

Doctor Verma, an associate professor in the Department of Psychiatry with a special interest in geriatrics, said the US has a situation where 12 to 13 percent of the population — the elderly — is taking up 30 percent of the hospital resources, mainly in acute care beds. He maintained many of these patients have chronic illnesses that could be managed at home with proper care and support systems.

"But our health care system does not provide for home care," he said.

He said if the medical community were to work with the social work system by tailoring available community programs to specific needs of an older person, many patients could be kept at home.

"The biggest thing is that we've got to shift away from is a model of curing problems to caring for problems — From treatment to management," Doctor Verma said.

Doctor Verma said he would like to set up a small-scale demonstration project in mid-Michigan to see if the concept would work in the US.

It works in Great Britain, he said, because people are used to the concept of health nurses and health visitors coming in to take care of matters Americans would only see their personal physicians about. In Britain, medical care is impersonal.

"You have your GP, medicine is rationed out, you're grateful for what you can get. It's an uncomplaining population," he sai "No one makes waves, and maybe that is why the system ca work."

In addition, Great Britain is a compact country of 20 million households in an area the size of Oregon.

"It's much easier to take care of Grandma and Grandpa from 20 miles away than from Califo nia to Michigan," Doctor Verma said.

He calls for a system of "respit hospitalization" in the US where older patients can be left by a family on vacation or one that simply needs a break from the routine of care. In addition, he likes the day hospitals in Britain where working persons can leav their elderly relatives while at work.

"At some point you have to g into a hospital for longterm care he said. "But between total func tion and total dysfunction, there are a variety of things that can happen."

Ethical paradox

Doctor Verma talked of the paradox of keeping older patien

Continued on page 5

Ms. Eberly is a Lansing-area freelance writer. This article was written while she was enrolled in a graduate-level overseas study program.

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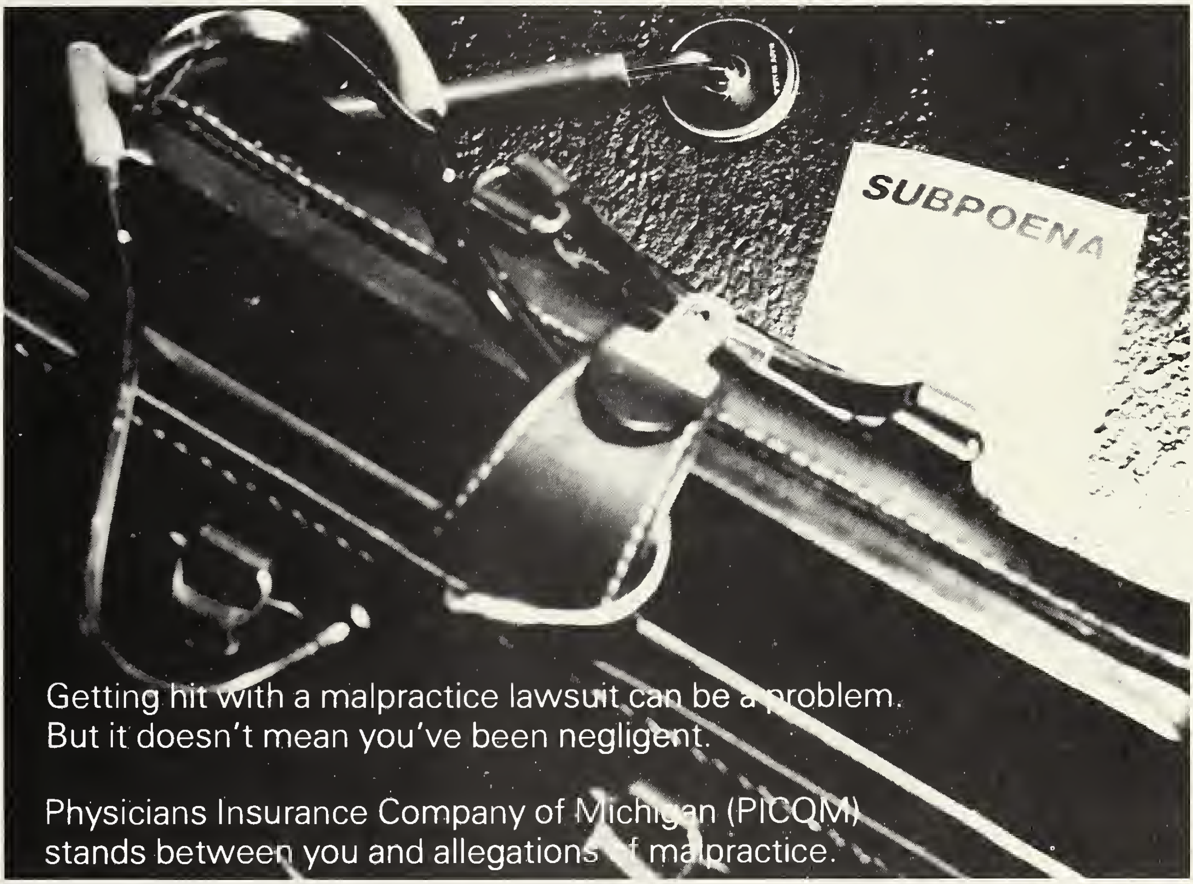

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ENGLAND/continued

alive by continuous treatment — something Britons don't routinely do.

"If you get older people in the hospital, you end up treating their pneumonias and bladder infections and so on," he said. "Now comes the paradox. You treat them, so you keep them alive longer. Therefore you've got to treat them much more.

"It's an ethical issue that I don't have any answers for," he added.

In Britain when an elderly patient has a chronic illness that simply isn't going to get any better, a much different view is taken of the situation than in the US. Instead of putting that person in the hospital for what may be years of on and off care, arrangements are made for the home method of care.

"We'll do as much as we can to keep the patient comfortable, but there are other ways of taking care of him rather than in a hospital," Doctor Verma said.

"That's the model I'm playing around with.

"But don't get me wrong. I'm not advocating euthanasia. I'm talking of the paradox that the longer you take care of people, the longer you perpetuate their problems."

Doctor Verma's office in the hospital is typically British - functional and, appropriately for someone connected with MSU, spartan. On the wall over his desk hangs his MSU pennant and a postcard of Spartan Stadium.

Growth, learning

He said the past year at Cambridge has been a tremendous opportunity for growth and learning for himself, his wife, Kiran — who did some work on her PhD dissertation in economics while there — and two daughters, 10 and 13. And, although he was busy, Doctor Verma said it was a different kind of busy.

"It's the kind of busy where your mind is free of clutter and you can work with problems," h said.

He said working at Cambridg University allowed him access t some of the top-flight minds in the world.

"It was wonderful finding thes dons you could tap, tucked awa here and there." he said.

Doctor Verma was impressed with the years of history in Cambridge, along with the graciousness of the people.

"Once you get beyond the initial British reserve, you'll find some very concerned and carin people," he said.

Doctor Verma also said he wa busy in the sense he served as sort of an ambassador of American medicine and "felt pleased and proud to do so."

However, Doctor Verma said his greatest experience was something that could be overlooked because it was so obvious.

"The biggest experience was realizing we're all facing the sam problems," he said.☐

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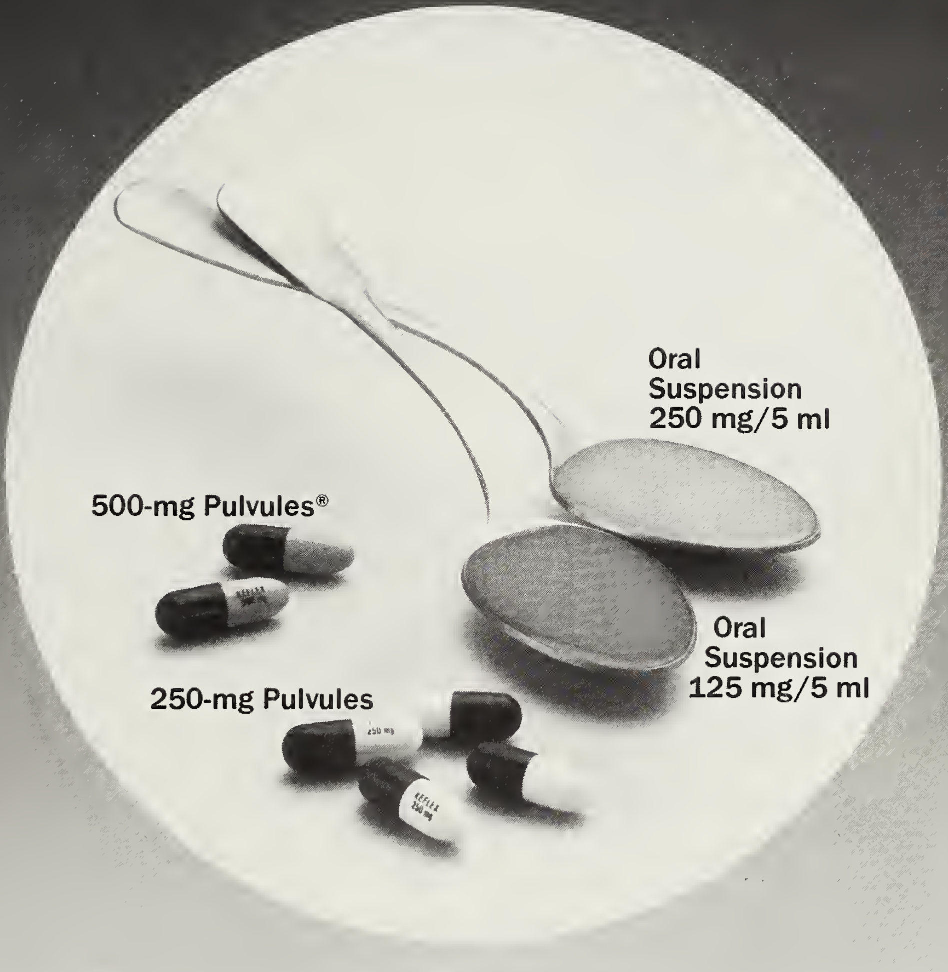
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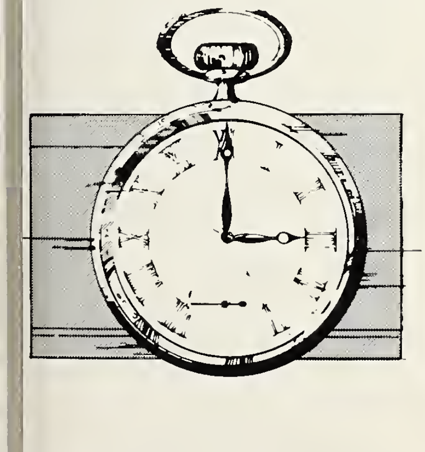

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By Sheri Greenho
Managing Editor

Two Michigan physicians received "Senior Honor Awards" from the American Academy of Ophthalmology in November. They are **Edmond L. Cooper, MD**, Birmingham and **Harold F. Falls, MD**, Brighton. The awards recognize commitment to teaching eye care diagnosis and treatment. . . . **James W. Gell, MD**, Bloomfield Hills, has been elected vice chairman of the Michigan Section of the American College of Obstetricians and Gynecologists for a three-year term. . . . The American Cancer Society honored **Vainutis Vaitkevicius, MD**, Detroit, for his outstanding contributions in the field of cancer control. . . . **Patti Peterson, MD**, Dearborn Heights, was named an outstanding alumnae of Northern Michigan University. She is a Muscular Dystrophy Association fellow at the WSU School of Medicine. . . . **Samuel Indenbaum, MD**, Detroit, is chairman of this year's alumni Telefund, a fundraising drive for Wayne State University School of Medicine. . . . **Frederick C. Swartz, MD**, East Lansing was named recipient of the ninth annual V.K. Volk Award by the Michigan Society of Gerontology for his years of dedication to the health care needs of Michigan's elderly. . . . Past president of the Genesee County Medical Society Auxiliary, **Evelyn Dykewicz**, was featured in the Flint Journal for her extensive volunteer work in the health field. . . . **Leonard F. Bender, MD**, Detroit, was one of two recipients of the WSU Alumni Association Alumni Faculty Service Award. The award recognizes efforts that bring about greater appreciation for the University's place in the community. . . . Vice chairman of the health professions division c Israel Bonds, and member of th group's executive board is **Susa E. Harold, MD**, Detroit. Doctor Harold recently completed a tw year term as president of the Michigan Chapter of Phi Delta Epsilon medical fraternity. . . . Th Michigan Academy of Family Physicians presented **David E. Blair, MD**, Grand Rapids, with th Parke Davis Teacher Development Award at a recent board meeting. . . . The Outstanding Se vice Award was presented to **Daniel S. Mazzuchi, MD**, Marquette, by the Upper Peninsula Medical Education Program for his leadership and dedication. . **Sydney F. Elias, MD**, Southfield is new chairman of the board o trustees of Michigan Health Ca Corporation. . . . New president of Genesee County Medical So ciety is **George H. Greidinger, MD**. **Robert E. James, Jr., MD**, i president-elect. . . . **Stephen Olson, MD**, Whitefish Bay was awarded a plaque of appreciatic for his contributions to the development of rural community health center programs by the Upper Peninsula Association of Rural Health Services. . . . **Raymond Hockstad, MD**, Escanaba, was honored by the Upper Peninsula Health Education Corporation for his efforts i bringing MSU's School of Huma Medicine student training cente to that city. Also honored were past board chairmen **Kenneth Light, MD**, Sault Ste. Marie and **Robert Glenn, MD**, Marquette. . . . **Stanley Brzezinski, MD**, formerly of Monroe, retired after practicing for 30 years in dowr state Michigan to his native Iro River. . . . **Michael McAlvey, MD** Hastings, is new president of Barry County Medical Society. . MSMS immediate past preside **Donald Crandall, MD**, Muskegon, has been appointed liaiso consultant with Blue Cross/Blue Shield of Michigan. He will wo with western Michigan physicia and the Blues on physician anc patient problems.

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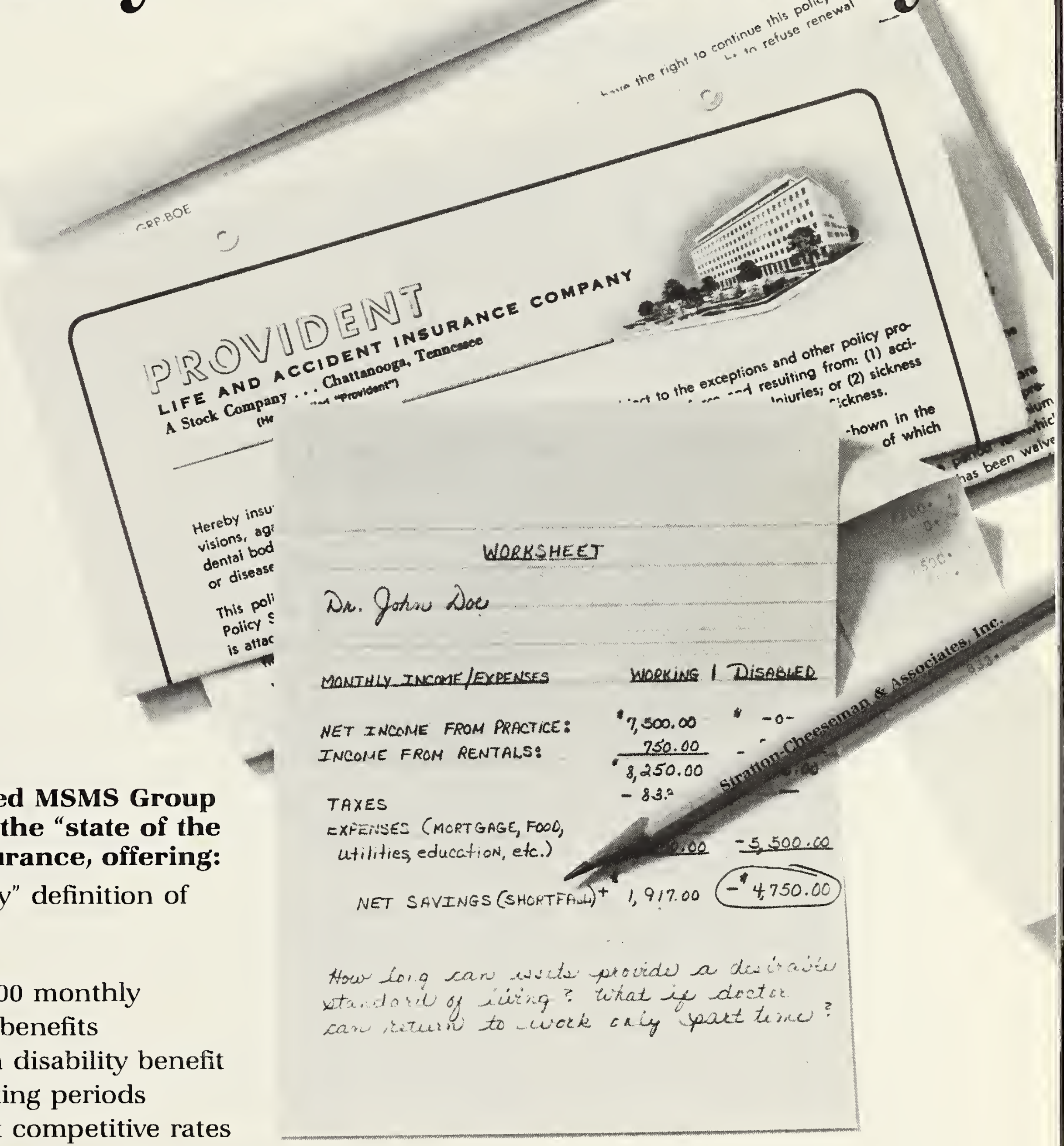

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AIDS and the treatment of hemophilia

The following guidelines, put forth by the National Hemophilia Foundation, are published here for physicians' information. The views expressed are those of that organization, and are not official positions of Michigan State Medical Society.

The National Hemophilia Foundation Medical and Scientific Advisory Council revised its recommendations concerning AIDS and the treatment of hemophilia in October, 1984. The updated information is published in its entirety, below.

I. Recommendations for physicians treating patients with hemophilia:

A. For patients with factor VIII deficiency, it is recommended that cryoprecipitate be used to treat patients in the following groups, with the recognition that there are some circumstances where viral attenuated (heat-treated) factor VIII concentrate may be appropriate therapy: newborn infants and children under 4; newly identified patients never treated with factor VIII concentrates.

Similar guidelines should be applied to factor IX deficiency patients where fresh frozen plasma can be used.

B. Desmopressin (DDAVP) should be used whenever possible in patients with mild or moderate hemophilia A. When desmopressin does not provide adequate treatment, these patients should be treated as specified in A.

C. We do not yet have sufficient data of scientific nature to know with certainty that viral attenuated (heat-treated) coagulation factor concentrates should now be universally adopted. However, very preliminary data do suggest that HTL-VIII is heat sensitive. Further, we do not know whether hemophiliacs who are positive for antibody to HTL-VIII have been exposed to living virus capable of causing AIDS, or have developed effective immunity against AIDS. Because heat-treated products appear to have no increase in untoward effects attributable to the heat treatment, we now recommend that treaters using coagulation factor concentrates should strongly consider changing to heat-treated products with the understanding that the protection against AIDS is yet to be proven. We again urge a prospective national study of these and other materials in patients not previously exposed to pooled blood products. In addition, further basic studies on the efficacy of viral attenuation procedures are urged. The Medical and Scientiuific Advisory Council with continue to review its position on heat-treated products as more complete studies become available.

D. All elective surgical procedures should be evaluated with respect to the possible advantages or disadvantages of a delay.

E. We reaffirm our position that patients continue treating bleeding episodes with clotting factor as prescribed by their physicians, as the risks of withholding treatment far outweigh the risks of treatment. Therefore, it is important that patient education and psychosocial support be provided.

II. Recommendations to factor VIII concentrate manufacturers:

A. Serious efforts should be continued to exclude donors that might transmit AIDS.

1. Blood and plasma donation should not be obtained from prospective donors who are members of groups who are at higher

risk of contracting AIDS. Such groups include: male homosexuals; intravenous drug users; those who have recently resided in Haiti; and sexual partners of members of those groups who are at higher risk. This effort should make use of educational materials and questionnaires in a discreet and sensitive manner.

2. Prospective blood donors should be excluded if they have symptoms associated with AIDS. This should be done by direct questioning and physical examinations as recommended by the Food and Drug Administration, Office of Biologics (March 24, 1983).
3. Research is encouraged in the evaluation and implementation (if verified) of surrogate laboratory tests that would identify individuals at high risk of AIDS transmission. With regard to HTL-VIII testing, we urge the continued rapid development and study of this and other laboratory tests which can identify blood donors at risk of transmitting AIDS. When the sensitivity and specificity of HTL-VIII antibody testing or other such tests are found to be sufficient, as verified by clinical trials, these tests should be then applied to all blood and plasma donors as soon as feasible.
4. Until effective blood donor screening methods are available, manufacturers should continue to avoid using plasma obtained from donor centers that draw from population groups in which there is a relatively high AIDS incidence.

Efforts should be continued to expedite the development of processing methods that will inactivate viruses potentially present in all clotting factor concentrates.

There should be an evaluation of the possibility that the yield of factor VIII in pheresis donors could be increased using DDAVP or exercise to maximize yield. This would permit a reduction in the size of the donor pool and would compensate for losses in plasma that might occur due to steps noted above.

Concentrate manufacturers should immediately cease purchase of recovered plasma for factor VIII concentrate from blood centers that do not meet criteria listed in II.A above. These criteria should also apply to the production of cryoprecipitate.

Manufacturers should withdraw any lot of concentrate if it includes material from an individual that has been identified as having AIDS, or from an individual that, in the best medical judgement of the manufacturers, has characteristics strongly suggestive of AIDS.

Manufacturers should accelerate efforts towards the production of coagulation factor concentrates by recombinant DNA technology. When such materials are ready for clinical trials and for introduction into clinical use, the necessary review processes should be carried out as expeditiously as possible.

. Recommendations to regional and community blood centers:

The production of cryoprecipitate should also adhere to criteria detailed in II. A above.☐

JAMA calls AIDS blood test helpful

A blood test that detects antibodies to HTLV-III, the virus causally implicated in acquired immune deficiency syndrome (AIDS), has been proved highly specific and sensitive. The finding is reported in the January 11 *Journal of the American Medical Association.* The test will be useful in screening blood donors and populations at risk for AIDS, and will help in defining the spectrum of diseases that are etiologically related to HTLV-III.

Stanley H. Weiss, MD, of the National Cancer Institute, Bethesda, and colleagues used the semiautomated test on blood samples from 88 patients with AIDS and 297 healthy persons. They found that 72 (82 percent) of 88 patients with AIDS were positive for antibody, 14 (16 percent) were borderline, and two (2 percent) were negative. "In contrast, only 1 percent of 297 volunteer blood donors were positive, 6 percent were borderline, and 93 percent were negative," the researchers say. Current precautions for health care employees appear to be adequate, since none of the 188 laboratory and health care workers treated had positive results.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: January 27-February 1, Ninth Annual Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Office of Continuing Medical Education of the University of Michigan Medical School. **Cost:** $295.00 **Contact:** Betty Phillips, Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor, 48109-0010, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: January 27-February 1, Schuss Mountain Conference on Emergencies in Medicine. Location: Schuss Mountain, Mancelona. **Sponsor** Wayne State University, Department of Surgery, and Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit, 48201 (313) 577-5009. **Approved for:** 25 hours of Category I Credit.

Date: February 4-6, Hemodynamic Monitoring VII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: February 9, Problems in Coagulation: The Clinical Pathologist as Consultant. Location: Burkei Auditorium of Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Kenneth McClatchey, Department of Pathology, University of Michigan, Ann Arbor 48109 **Approved for:** 3 hours of Category I Credit.

Date: February 27, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved for:** 8 hours of Category I Credit.

Date: March 9, Type II Diabetes. Location: Michigan Osteopathic Medical Center. **Sponsor:** Michigan Osteopathic Medical Center. **Cost** $10.00 (There is no fee for Residents, Interns or Externs). **Contact:** Medical Administration, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr. Blvd., Detroit, MI 48208, (313) 361-8020. **Approved for:** 5.5 hours of Category I Credit.

Date: March 20-21, Michigan Conference on Maternal and Perinatal Health. Location: Hyatt Regency Dearborn. **Sponsor:** MSMS. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 13 hours of Category I credit.

Date: March 22-23, Second Annual Chronic Pain Symposium. Location Sheraton Fashion Square, Saginaw. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City, MI 48706, (517) 892-1501. **Approved for:** 13 hours of Category I Credit.

Date: March 28, Practical Approach to the Diagnosis and Treatment of Diabetes Mellitus and Related Problems. Location: Fetzer Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center and the Michigan Affiliate of the American Diabetes Association. **Cost:** $40.00.
Contact: Charles L. Zeller, Jr., MD, Director of Continuing Medical Education SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 5 hours of Category I Credit.

Date: April 10, Primary Care Medicine An Exciting Frontier Revisited. Location Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education 2799 W. Grand Blvd., Detroit 4820 (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: April 25-26, 14th Annual Wayne State University Critical Care Symposium. Location: Northfield Hilton, Troy **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma, and Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 557-500 **Approved for:** 12 hours of Category Credit.

Date: May 6-8, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical Center. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

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FULL AND/OR PART TIME EMERGENCY MEDICINE positions in Southwest Michigan. Must be ACLS certified. Send CV to P.O. Box 76, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

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Improvement of maternal/perinatal health is MSMS conference goal

MSMS educational leaders recently made a survey and unexpectedly happy results were determined.

They uncovered the impressive information that MSMS sponsored 27 conferences and meetings in 1984, attended by 4,700 persons. MSMS awarded 24,000 Category I CME credits to physicians during the year.

These figures do not include the 16 meetings that MSMS cosponsored with other health care organizations.

Two jewels in the MSMS educational crown are the Annual Scientific Meeting in November, and the Michigan Conference on Maternal and Perinatal Health each spring. Together, these meetings are responsible for half of the total participation in MSMS meetings.

This latter conference is the subject of this column.

A delicate balance

As you can see from the cover story this month, the 1985 event is scheduled for March 20-21 at the Hyatt Regency Dearborn. The theme this year is "Maternal/Perinatal Health: A Delicate Balance."

As your next MSMS president, and as an obstetrician/gynecologist, I am particularly proud of this conference. This meeting annually draws approximately 1,000 persons and is one of the most vital conferences to the improvement of medical care in our state.

Doctor McMurray

The planning of this year's conference is in the capable hands of co-chairmen Rudi Ansbacher, MD, Ann Arbor and Robert W. Dustin, MD, Dearborn, both leaders in the field of maternal and perinatal health.

Let's take a look at some of this year's conference subjects: Topics include "The Nurse/Physician Relationship," so critical to optimum medical care delivery; "A Multidisciplinary Approach to Perinatal Loss;" and "Management of Postpartum Bleeding."

Other sessions will take up "Care of the Very Low Birthweight Infant," with special emphasis on nursing and neonatal aspects of this important problem in our state. "Malpractice in Obstetrics - Legal Aspects" will feature case studies and commentary from doctors and lawyers.

Roundtable talks

A special feature of the annual Maternal Health Conference is the array of choices of informal, roundtable discussions with key speakers during lunch.

This year's roundtable topics include "Ethics in Relation to the Malformed Fetus," "Prolonged Pregnancy," "Neonatal Nursing," "The Addicted Fetus and Newborn," "The Obstetric Nurse Practitioner;" "Ethical Decisions Related to the Handicapped Newborn;" "Office Sonography;" and "Nursing Liability."

Infant mortality

Of concern, a major medical problem in Michigan is the high infant mortality rate in metropolitan areas. Early in March, a Blue Ribbon Task Force of the state's Department of Public Health concluded that 10,000 Michigan women do not get adequate prenatal care.

The governor subsequently se aside $1,000,000 in his budget to help meet this need.

The high infant mortality rate has sparked a special governmental/legislative push to improve the health of inner city women. Rep. Alma G. Stallworth (D-Detroit) recently sponsored legislation to allow minors to obtain prenatal care without parents consent, (see article page T.C. o this issue). The bill, now law, states that physicians delivering that care no longer are at risk o being charged with assault shoul they do a pelvic examination on a minor.

Our coming 1985 Michigan Conference on Maternal and Perinatal Health will do much to improve medical care for mother and their babies by bringing together 1,000 of the most interested and effectual persons in ou state. If you have an interest, an want to make a difference, plan to attend this conference. I am proud to announce it to you an to be associated with this fine MSMS program.☐

Doctor McMurray, Flint obstetrician/gynecologist, is MSMS president-elect. He writes this month at the invitation of MSMS President Louis R. Zako, MD. Doctor McMurray will be installed as president April 27 at the MSMS House of Delegates meeting in Southfield.

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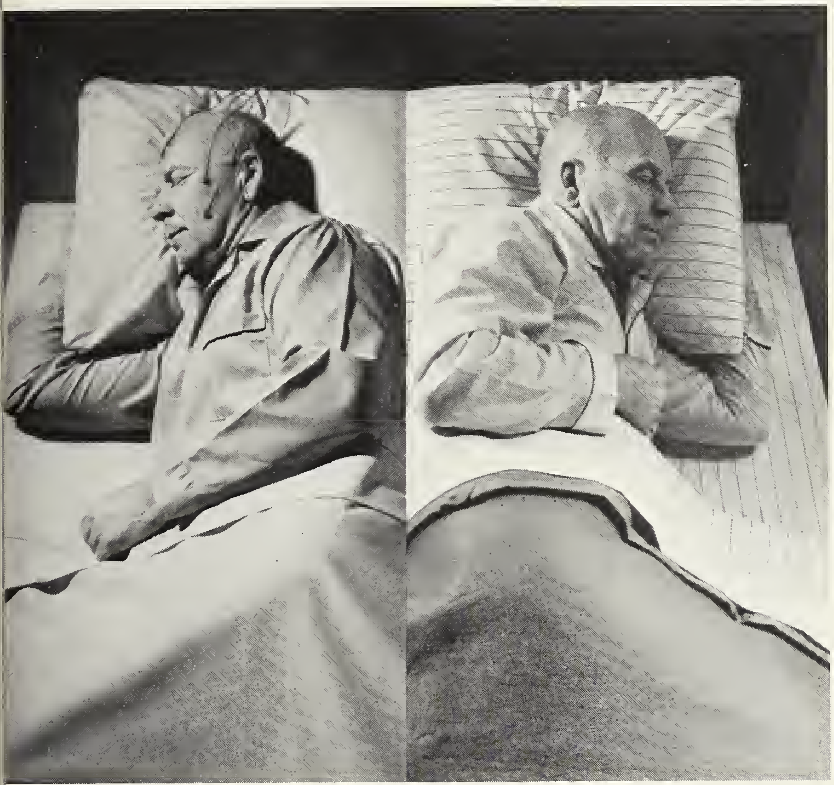

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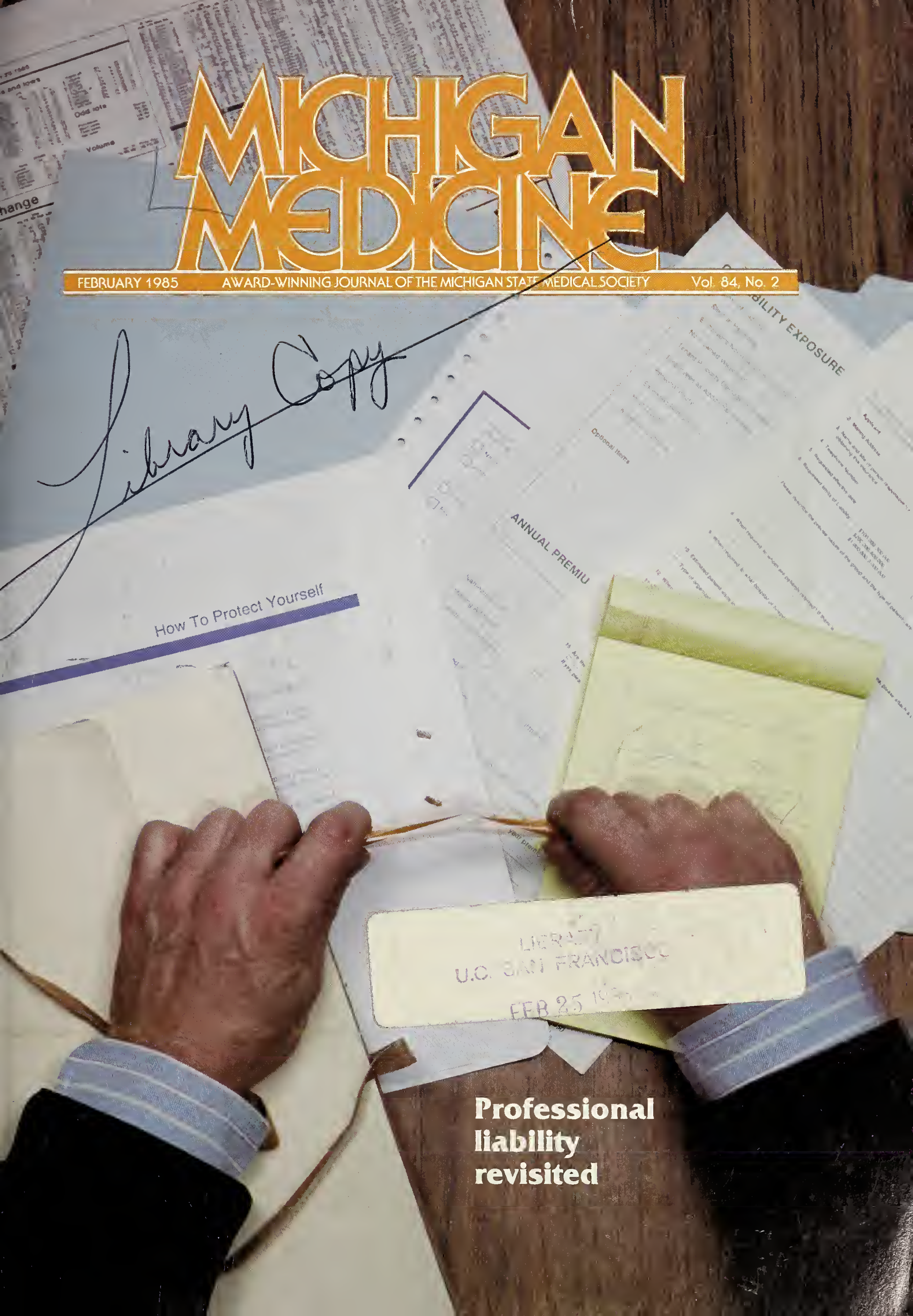
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an Medicine:
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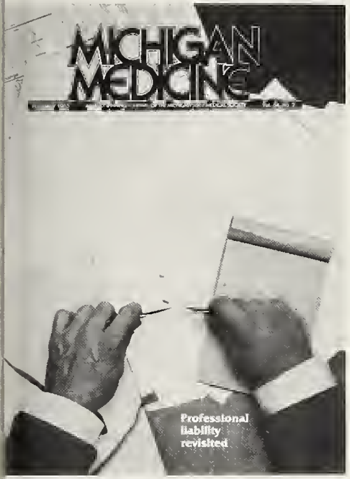

bout the cover:
he current professional liability ituation is nothing if not frusrating for Michigan physicians.
hoto by Kim Kauffman

n next month's issue of *Michi-an Medicine:*
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Special report

72 There are several theories as to how the medical professional liability situation reached this critical point, and there are several theories as to how to improve it. Inside are articles on the AMA's and MSMS's stances; the insurance availability problem; a carrier's viewpoint; legislative solutions; steps individuals can take; arbitration; no-fault insurance, review panels as solutions; and wrongful death cases: Daniel G. Beyer, JD; Robert M. Leitch, MD; Judy Marr; Richard J. McMurray, MD; Michael S. Mullen; Rhoda M. Powsner, MD, JD; Susan M. Schmidt, JD; Thomas E. White

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Your success is evident by the increase in the number of exhibitors. I take every opportunity to promote the convention among representatives of companies who have not attended recent conventions. I would like to see a greater participation by the pharmaceutical companies. Perhaps the MSMS can learn who the decision makers are and contact them personally. I know that many companies are cutting back on meetings but the MSMS is not one they should eliminate from their schedules. I would be happy to testify in any promotion you use. As for 1985? It will mark Saunders fiftieth year as a participant in your annual meeting. Naturally, we shall be there.

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By Richard J. McMurrary, M

AMA's liability crisis stance growing more aggressive

The American Medical Association's level of involvement in the medical liability crises of the last decade has varied, recently growing more aggressive. In 1974, a less assertive posture seemed appropriate; today it does not.

Ten years ago, increased premium costs for liability insurance were troublesome, but the big concern was the lack of available carriers. The combination of a faltering stock market and increasingly large judgments in the courts severly cut insurers' reserves and liability policies became unprofitable.

The situation spawned physician-owned companies capitalized through many methods, but primarily by physicians. At the time, the AMA created an "umbrella" company which allowed the primary state companies a ready access for reinsurance and excess limits.

A concurrent AMA push was for tort reform through state legislatures. Tort reform remains an ongoing process in Michigan although legislation providing "special interest" relief, as opposed to general tort reform, is both difficult to achieve and vulnerable to constitutional challenge.

Yet, it has become obvious that tort reform efforts simply weren't enough. At the AMA's annual meeting in June, a prime concern of the delegates was medical liability and the ineffectiveness of the Associations's efforts to date.

An AMA committee on medical liability presented a report to the House of Delegates which was essentially fact-finding in nature and offered no course of action. Many viewed this as unsatisfactory and, at the conclusion of the session, Chairman of the Board of Trustees, John J. Coury, MD, announced that a special task force would be created to study the problem of medical liability. Further, it would carry top priority for action.

Two reports subsequently have been published, consisting mainly of background information. As medical malpractice claims have increased at a faster rate than any other types in the last 15 years, the AMA has attempted to identify the reasons for the increase. It has found simple answers.

While it is true that the reason for malpractice claims *is* malpractice, this *alone* cannot account for the explosion in number and severity of claims. Evidence shows that physicians today are better trained and practice higher quality medicine than ever. Medicine is more sophisticated and its technologies more advanced. As the Rand Corporation's Institute for Civil Justice concluded in 1982, "The diversity and growth in claims frequency are partly the result of changes in medical services and would therefore not be eliminated even if legal environments were uniform."

Part of the problem may lie with the courts. Still other contributing factors include higher public expectations of what medicine can offer, a more litigious society, and greater numbers of lawyers willing to file suits with the lure of possible high awards or settlements.

The AMA continues to work diligently for the answers to the medical liability problem. Legislative changes probably don't offer the solution, though the AMA still may attempt to put together a model legislative package for individual states to enac Certainly, federal legislation seems infeasible.

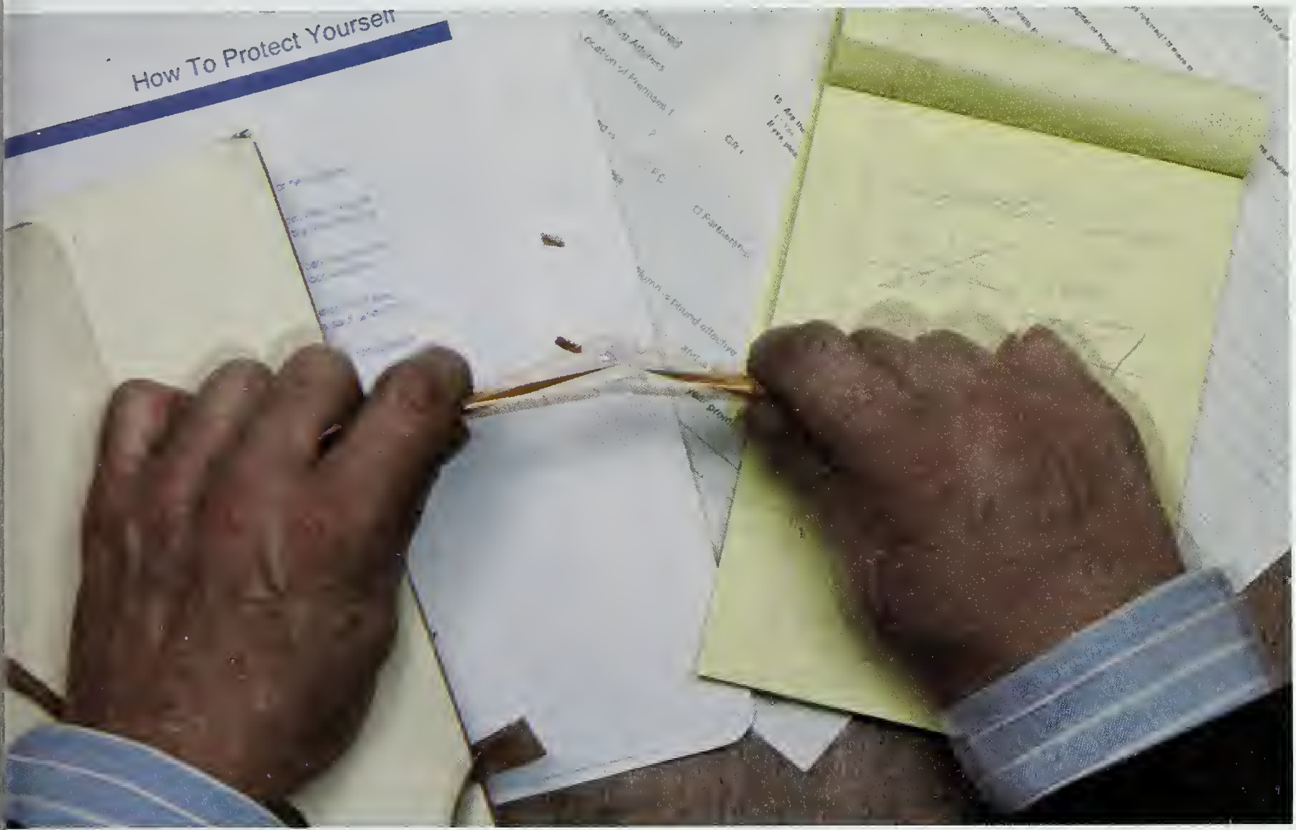
AMACO, the AMA reinsuranc company, remains healthy and should continue to provide fisc stability for the state-owned companies.

The problem now, when one out of every five physicians can expect to be sued, is affordabilit Other authors in this section suggest the high cost of insurance is leading to availability problems. The AMA task force on medical liability shortly shoul have a recommended action pla prepared to guide AMA efforts in resolving the problems.

The best hope at present—an perhaps for the future—will be to practice the best medicine possible, improve physician-patient-family communications, an ensure that patients understand procedures, risks, and the possibility of unfavorable results. We must reduce unrealistic expectations. We must continue to evaluate risk management processes and techniques. And we must keep complete and accurate records.

In short, despite the power an resources of the AMA, the *real* solution to the medical liability problem is to treat our patients to the best of our abilities and in the manner we would like to be treated.☐

Doctor McMurray, Flint, is chairman of the Michigan delegation to the AMA, and is MSMS president-elect.



Insurance availability is a major problem in Michigan

The medical malpractice problem in Michigan has evolved ver the past 10 years from one availability to one of cost of at insurance. Now, because the ost has increased dramatically, e problem once again is avail- bility.

That was the report in October y William Cheeseman, adminis- ator of the Michigan Physicians lutual Liability Company. Mr. heeseman was one of the par- cipants in a brainstorming ses- on called by MSMS President ouis R. Zako, MD.

He and MPMLC President obert M. Leitch, MD, spoke from eir eight years of experience the field. MSMS founded the ompany during the malpractice isis of 1976.

"There's a lot of activity in the malpractice arena and it isn't getting any better," said Doctor Leitch. He added, however, that for MPMLC, the activity appears to be tapering off.

MPMLC averages 100 lawsuits filed per month, and $40,000 per paid claim, he said.

"Four to five years ago, we averaged $25,000 per paid claim, and 18 cases per month. These figures surely will continue to go up."

Premiums are going up, too, he reported.

"Nationally, in 1983, physicians paid $1.45 billion in premiums," he said. "In 1984, we expect this figure to be between $1.65 and $1.75 billion."

In 1979, the average premium paid by MPMLC insureds was $4,415. In 1983 the figure was $5,843.

"This is a severe problem—very severe—and there's a lot of it," Doctor Leitch said. He elaborates on the causes in an accompanying article, saying that the catalyst behind lawsuits, in most cases, *is* malpractice.

The National Association of Insurance Commissioners, he said, estimates that only 10 percent of malpractice suits filed are frivolous, and the payout for indemnity of this 10 percent is just one percent of the total. "The thing we as physicians have got to address is how to decrease patient injury," he said. "Until we do, we are not going to be very successful in alleviating these insurance problems." JM ☐

By Michael S. Mulle

Medical liability insurer assesses Michigan's plight

Twenty-five years ago, general surgeons throughout Michigan, Indiana, Missouri and Kentucky paid the same premium for occurrence coverage from The Medical Protective Company for $100,000/$300,000 limits. Fifteen years later, a sizable differential developed, with general surgeons in Detroit paying 2.5 times the premium paid by a general surgeon in Louisville. The rates charged general surgeons today for the same $100,000/$300,000 coverage are:

	Annual Premium
Detroit	$16,494
Grand Rapids	$11,011
Missouri	$ 7,365
Kentucky	$ 6,227
Indiana	$ 4,521

A direct relationship exists between the legal environment and malpractice premiums paid by doctors. The escalation of premiums for Michigan doctors reflects the troubled legal environment in Michigan.

Two primary factors affecting cost are:

1. The number of claims filed against physicians charge in Michigan.

2. The unwillingness of the court system in Michigan to allow physicians who are not the primary defendants to be released from litigation drives up both defense and indemnity payments. The concept of joint and several liability says all physicians thus held in a case by a court are financially responsible no matter what degree of involvement the physician had with the claimant.

Because of prejudgment interest and because doctors with only the slightest relationship to a claim are held in until disposition, both defense costs and indemnity payments in Michigan are higher than in other jurisdictions. This is reflected in the premiums paid by Michigan physicians.

The outlook for physicians in Michigan is not good. Stability is lacking in the legal environnment, and this can only cause increased payouts resulting in increasing premiums. For the medical liability climate to improve, stability is essential. The most stable state in the country today is Indiana which pioneered workable legislative reform in 1976. At the pr sent time effective legislative re form is the most viable solutior to the impending crisis of affor dability of professional liabillity insurance for physicians.

On an individual basis, there are some measures which ever physician can take to lessen individual exposure:

1. Know and understand the medical standard of care owed to your patients.

2. Be aware of the limitations of your treatment and discuss these limitations candidly with your patient.

3. Maintain good records of your treatment and the reasons for your selection of a given trea ment.

Financial stability is the most important consideration in selec ing a professional liability company. Your accountant and/or fi nancial advisor can help you de termine the financial security of a company. Given an unstable legal environment the only reasonable alternative for cove age is a company which will be available to service your needs in the future.

The Michigan picture is not good. Premium costs will increase as litigation and costs ir crease. At this time, there is nc reason to believe litigation and costs will not increase. This unstable environment does not serve the medical community, and will, in turn, negatively affe the care and treatment availab to citizens of Michigan.☐

Mr. Mullen is executive vice president, The Medical Protective Company of Fort Wayne, Indiana.

By Susan M. Schmidt, JD

Tort reform as a remedy

In response to the professional liability crisis in the mid-eventies, physicians and other ealth care practitioners and roviders went to the state leglatures seeking to find a soluon. The crisis was one of lack f availability of coverage at any rice - carriers were fleeing the arket. The medical profession ok the lead role in supporting nactment of tort reforms with ore than 300 bills enacted.

Now that there is a ten year ack record, what impact have ese tort reform measures had n the professional liability probms of the medical profession? e answer depends upon the ate in which a physician praces and what is occurring in rms of increased premiums. me argue that the tort reforms ave been successful in addresng the availability of coverage roblem and that without the easures today's professional bility problems would be much orse. Others point to the ineasing number of claims and its and the severity of awards d argue that the tort reforms ave had no more effect than a andaid on an eight inch cut. A ore accurate response may lie mewhere between. The medil profession has continued to nsider tort reform as an integral art of an effort to alleviate the rofessional liability problem.

gal challenges

Tort reforms enacted during e seventies have been subject to several types of legal challenges. One of the most common challenges is that the reforms violate the equal protection guarantees of the federal or state constitutions. By treating one type of plaintiff or defendant (i.e. medical negligence) differently than other tort plaintiffs or defendants, constitutional rights are violated.

Tort reform provisions also have been challenged because they deny free and equal access to the courts by placing barriers or imposing prerequisites to filing lawsuits. Due process violations or impairing the right to jury trials have been the basis for other challenges to tort reform provisions. Other provisions have been invalidated as part of a comprehensive tort reform package that could not be severed. Despite these legal challenges, several tort reform provisions are likely to alleviate the professional liability situation and frequently are sought in tort reform efforts.

Specific provisions

One of the most common tort reform provisions, one thought to be effective in reducing the cost of medical liability litigation, is a cap on awards. Twelve states now place some type of limit on liability. Indiana's and Nebraska's state Supreme Courts have upheld limits on awards in those states. To avoid some of the equal protection challenges to absolute caps, some states have limited certain elements of an award. In 1984, physicians in Florida unsuccessfully attempted to place a general tort referendum on the ballot that would, in part, have limited non- economic damages to $100,000. In Illinois and New York, proposed tort reform packages would place a limit of $100,000 on non-economic damages.

Another common tort reform is modification of the collateral source rule to allow introduction into evidence or reduction of an award by compensation received from third parties. Two kinds of changes generally have been enacted. The first, originally adopted in nine states, eliminated the collateral source rule and gave the judge or jury discretion to consider the plaintiff's other sources of compensation in determining damages. In ten states, the collateral source rule was retained, but a mandatory offset of the amount of compensation from other sources was required.

A third tort reform provision, one adopted by the greatest number of states, is modification of the statute of limitations to shorten or clarify these statutes for medical liability claims. In addition, twenty three states enacted laws modifying the statute of limitations period for minors. In general, efforts to shorten the statute of limitations have withstood court challenges. In three states, however, courts have struck down the shortened statutes of limitations for minors because they arbitrarily denied the minors right to seek redress for injuries.

Periodic payments are another tort reform aimed at reducing the cost of medical liability litigation. Seventeen states have passed statutes that require or permit courts to award damages periodically, rather than as a lump sum. Lump sum awards have been criticized because if a plaintiff dies earlier than expected, the

Continued on Page 76

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s. Schmidt is coordinator, Special MA Task Force on Professional Liality and staff member of the AMA's ealth Law Division. References for is article are available from MSMS adquarters.

plaintiff's heirs may receive a windfall from the portion of damages awarded for future damages. Periodic payments insure that funds necessary for medical care will be available when needed. Structured settlements may lessen professional liability costs because insurers can fund them at a substantially lower cost than lump sum payments, savings can be passed to providers in the form of lower professional liability insurance premiums, and these savings may translate into lower fees for patients.

Other tort reform measures have focused on the legal process, such as expert witness or standard of care rules. The AMA continues to believe that tort reforms can affect the professional liability situation. Alone, however, they are not enough.

Complexity of the issue

Tort reform is essential. Yet, professional liability issues are not easily defined and are not susceptible to quick or easy solutions. A multifaceted approach is needed.

Education is needed, from health policy makers to patients. Professional liability is not a "physician-problem", but a societal one. The professional liability situation does affect the quality, access, and availabiity of medical care. Education of all segments of society is necessary to create an understanding of the nature and effects of this problem.

Physicians must take a more active role in addressing the professional liability situation. Developing strong physician-patient relationships is within the province of every physician's practice and may be the single most important method to avoid lawsuits. Physicians must also work to educate their patients, their local public opinion makers and others involved in this field as to the effects of professional liability on the cost and quality of medical care.

Tort reform is an essential component of any strategy to alter the current professional liability situation. However, the experience of the 1970s shows tha tort reform alone cannot eliminate the professional liability problem. The problem is broad-based and a broad-based approach is necessary.☐

MSMS initiatives to date

MSMS experts display little hope for improving the state's medical malpractice situation through legislation.

In fact, Frederick V. Minkow, MD, Pontiac orthopedic surgeon who heads the MSMS Committee on Professional Liability, has expressed a great deal of frustration with the legislative process.

Because of the lack of legislative redress, MSMS President Louis R. Zako, MD, convened 25 physicians in October for a shirtsleeve session on possible solutions to the malpractice situation.

Doctor Minkow was one of several physicians to testify for the MSMS omnibus bill to improve the malpractice outlook. This five-part bill—SB 224—has remained in the Senate Judiciary Committee's hands as its chairman seeks medical/legal accord on the bill's provisions. Senator Patrick McCullough (D-Dearborn) is the primary sponsor of the bill.

"The legislative directive to do something with the bill is up against the wall," said Doctor Minkow at the MSMS shirtsleeve session. "My experience is that there is no place to go."

More recently, in a report in the Oakland County Medical Society "Bulletin," he commented, "My general impression. . .is that it will be extremely difficult to get reform through the state legislature."

Participants in the October session, therefore, decided on a four-point approach which Doctor Zako recently presented to the MSMS Board of Directors:

1) To support the Michigan Medical Arbitration Program;

2) To study the benefits of the Wayne County Medical Society's voluntary physician defense panels;

3) To educate physicians to reduce the incidence of malpractice, to aggressively seek out unscrupulous physicians and to remove them from practice;

4) To find alternatives to the present tort system, including the no-fault medical malpractice insurance concept.

Already MSMS leaders have met with Professor Jeffrey O'Connell, architect of the no-fault medical malpractice insurance concept, and with the three majo medical liability insurance companies to learn firsthand why rate are rising and how the carriers plan to control the increases. Doctor Zako has scheduled a March 6 meeting of MSMS lead ers and the state insurance commissioner to further discuss malpractice insurance problems and active promotion of arbitration.

In an additional effort to ameliorate the situation MSMS delivered a letter to Governor Blanchard requesting that he ap point a broad-based Commissic on Professional Liability to explore solutions and approache to the Michigan liability climate. In the legislature, Rep. Matthew McNeely (D-Detroit) is expecte to establish a subcommittee of the House Insurance Committe to discuss professional liability problems.☐

By Robert M. Leitch, MD

Resolution of the crisis begins in the doctor's office

The solutions to or remedies for the professional liability crisis of the mid-1980s are legion. Myriad proposals have been offered to reverse the present situation, each with its own group of advocates; each group firmly convinced that it has the ultimate solution. The professional liability situation has been blamed for the increased cost of health care, for defensive medicine, and for developing an adversary relationship between patient and physician.

During the crisis of the mid-1970s physicians accepted various programs proposed as having the potential of speedy relief of our problems, but in the area of insurance we were convinced that the commerical insurers were not handling claims properly. We thought that if we could develop our own companies and review the claims ourselves, we could then grasp the causes of suits and claims and eliminate them, thus eliminating the entire problem.

More than thirty medical groups have developed insurance vehicles of one sort or another toward this end.

But physician insurance companies have not been able to reverse former trends. We still continue to chase "will-o-the-wisp" solutions through legislative relief, changes in the imposition of legal fees and the like. One state medical society even attempted a referendum approach to the problem in the supposition that people would, by their votes, somehow improve the situation.

Facing facts

The time has come for the medical profession, from individual practitioners to the upper echelons of organized medicine, to face the fact that physicians can make the greatest progress toward reducing litigation by changes in their behavior, vis-a-vis the practice of medicine. The greatest lesson learned over the years is that the majority of claims result from patient injury - with or without negligence. Pure carelessness on the part of a treating physician may produce serious injury which generates the payment of large sums in compensation. Misdiagnosis causes a great deal of trouble and expense. Improperly performed procedures or inappropriate procedures are the basis of many claims. Inadequate consultation can lead to litigation. None of these, nor any other factors of physician inadequacy can be legislated away. We physicians have to make the changes ourselves!

Many claims might be successfully resisted or defended if supported by adequate records. We see illegible, incomplete, irrelevant records and in some cases, no records at all with which to support a doctor's activity. Legislation and tort reform cannot correct this problem.

Bedside manner

The quality of the physician-patient relationship can be a determining factor in a decision to sue over a less-than-perfect result. The physician's manner, billing procedure, fee structure or attitude toward his patient all are potential sources of trouble. The physician who develops a good relationship with his patient is less likely to be sued because "people don't sue their friends."

The changes which physicians must make in their behavior will not be made easily: the habits of a lifetime of practice are not easily changed. However, until physicians take inventory of the deficiencies in their practices, outside measures will do little to solve liability problems.☐

Doctor Leitch, Battle Creek, is president of Michigan Physicians Mutual Liability Company.

By Rhoda M. Powsner, MD, J

Michigan physicians should promote arbitration program

At the October special meeting on professional liability called by MSMS President Zako, the concensus was that a number of steps should be taken to help alleviate the current medical malpractice "crisis". One of these was vigorous support of the Michigan Arbitration Program which has been declared constitutional by the Michigan Supreme Court.

Enacted during the "crisis" of the mid 1970s, the Arbitration Statutes were part of a broad program of legislative reform aimed at providing relief so that insurers would not continue to withdraw from the state. Its supporters hoped that the arbitration alternative to the court/jury system would provide a fair, faster, less costly and more predictable method of conflict resolution, one which would allow adequate remuneration for injuries while holding excessive litigation costs. In addition, they felt that arbitration would circumvent arbitrary and capricious decisions characteristic of juries in some areas. (See the recently released study by the Rand Corporation's Institute for Civil Justice which notes that job related injuries and those occurring as the result of defective products receive up to four times as much money in successful lawsuits as similar injuries incurred in traffic accidents and other mishaps.)

The Michigan Arbitration Program got off to a slow start for may reasons: the opposition of the hospital community to the strict requirements for proper implementation of the statutes; the marked hostility of the plaintiff bar which believed patients' constitutional rights were being abridged, and the concern of many physicians that discussions of issues inherent in signing the arbitration agreement might tend to encourage rather than discourage suits. The combination of these factors, plus a less than adequate consumer education program, contributed to the lukewarm reception of arbitration as an an alternative to the Courts for resolving alleged malpractice disputes.

The Michigan Arbitration Program was virtually at a standstill in 1982 when the Michigan Court of Appeals found the Act unconstitutional in 14 cases and constitutional in 14 others. As can be seen from Table I the number of filings with the American Arbitration Association had diminished to a trickle. This trend has been dramatically reversed since March of 1984 when the Michigan Supreme Court declared the program to be constitutional.

In November of 1984 the Arbitration Advisory Committee completed its evaluation of the Michigan Arbitration Program in accordance with its legislative mandate. Obviously the growth of the data base had been hampered by the constitutional challenges. But analysis of 2,611 closed claims opened after January 1, 1976 and closed between June 1, 1978 and June 1, 1982 in both arbitration and the court provided sufficient material to permit statistical comparisons o arbitration and the court/jury system. Arbitration was found to b a fair, faster, less costly and mor predictable method of conflict resolution. The spread of awards from several hundred dollars to $15 million (structured settlement) gives some indication of the nature of the injuries with which this system has been able to contend.

Subjective information obtained from surveys of the man groups involved in the arbitratio program revealed some weaknesses in the hospital offering procedures, continued concern about fairness by plaintiff attorneys, but an overwhelming sens of fairness of the system on the part of arbitration panelists. Ove 90 percent of the medical community surveyed expressed a preference for arbitration over th court/jury system.

It is obvious that some sweeping changes are going to be made in the manner in which injuries resulting from medical malpractice are handled. Medic malpractice no longer is considered just negligent delivery of medical care. It encompasses overwhelming societal expectations that contact with the healt care industry will result in a favorable outcome. Individual physicians not only are becomin less able to deal with large insurance premiums but also are emotionally stressed by the thre of malpractice suits. Many are giving up high risk practices. O course, problems evolving fro

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Doctor Powsner is an Ann Arbor cardiologist who serves on the Arbitration Advisory Committee to the Michigan Medical Arbitration System. She is a member of the MSMS Task Force to study no fault professional liability insurance.

oth the financial burden im- osed by high premiums and the iminished access to care do not est on the physician community one, but are being passed on o the population as a whole.

The positive effects of the tort eform of the 1970s have for the ost part dissipated. In Michigan is year there has been no meet- g ground for the legal and edical professions, as physi- ans have attempted to achieve rther tort reform in the legisla- re. Frustrated in its attempts to neliorate the burgeoning prob- m within the tort system, MSMS considering the establishment a modified no-fault pilot pro- ct in this state.

We believe that the ultimate solution of the professional lia- lity problem is going to involve everal forms of conflict resolu- on. These probably will include bitration, as well as some form no-fault.

In the meantime, as attempts deal with the "malpractice isis" are sweeping across the nited States, only the people Michigan have a constitutional edical arbitration program hich is a fair and less costly al- rnative to the court/jury sys- m.

The constitutional issues have een resolved, and the Michigan rbitration Program has demon- rated its effectiveness. Now lichigan physicians should urge ospital administrators, attorneys nd patients to use arbitration as alternative to the court/jury stem in the interest of cost ontainment, timeliness, and fair- ess.□

By Thomas White

No-fault expert explains advantages

Investigation of a no-fault malpractice insurance system is underway at the direction of MSMS President Louis Zako, MD and the MSMS Committee on Professional Liability. A December *Michigan Medicine* article on such a system is excerpted here to lend balance to this Special Report:

Jeffrey O'Connell, professor at the University of Virginia School of Law, and co-developer of no-fault automobile insurance, addressed the subject of professional liability recently at the MSMS Public Affairs/Leadership Conference. A major portion of malpractice costs, he said, are litigation expenses.

A way to reduce the overall cost of malpractice insurance is by using a no-fault approach to handling malpractice claims, he suggested. Under a no-fault approach, patients who incurred an injury would, after verification of the injury, be automatically offered a predetermined settlement regardless of where the fault for the cause of the injury lay. In other words, the insurance company would create a set of criteria to identify situations in which it automatically would offer the patient a settlement.

The "beauty" of this approach, according to O'Connell, is that because the criteria for triggering a settlement offer are established prior to any compensable event, and because the offer will be made every time the event occurs, no admission of culpability can be inferred from the presentation of the offer. As well, the injured party would be given a limited amount of time, say 90 days from the date on which a settlement was offered, within which to accept or reject the tender. If the victim accepts the settlement he/she signs a statement waiving the right to pursue a claim in tort.

O'Connell suggested that the amount of the settlement be limited to the net economic loss, including medical expenses and wage loss (the latter with a cap of something like $300 a week) beyond the victim's own collateral sources such as health insurance, sick leave, etc. Benefits would be paid month by month as loss accrues. No compensation would be offered for pain and suffering. O'Connell suggested that any victim's attorney who advised or persuaded his/her client against accepting a no-fault settlement would be at risk if the client pursued the claim in tort and came up empty-handed.

There are two ways to initiate a no-fault malpractice system: legislatively or through a contractual approach. On the national level, legislation currently is being proposed, which would provide incentives for states to adopt model state legislation for a no-fault system. The AMA has opposed this legislation on the basis that the malpractice insurance problem is different in each state and should not be addressed with the broad brush of federal legislation.

According to O'Connell, a contractual approach could be taken in the absence of legislation but with the approval of the state's insurance commissioner. The contractual approach enables the insurer to craft a no-fault contract for a very specific set of circumstances which the insurer finds are actuarially sound. Thus, the contractual approach provides more flexibility and control for the insurer than would exist if no-fault malpractice were addressed statutorily. □

Mr. White is chief of the MSMS Section on Hospital/Physician Relations.

By Judy Marr, Editor

Defense lawyer says no-fault liability insurance may not be the answer

As Michigan proponents consider no-fault insurance as a solution to the medical malpractice situation, they should heed James L. Griffin's second opinion.

Griffin, a Philadelphia medical malpractice defense lawyer and consulting editor to *Medical Economics*, says that by modifying our present system we could come out with an even better solution.

"The increase in lawsuits has nothing to do with the tort system," he said, speaking to a 1984 meeting of the Physicians Insurance Association of America in Lake Tahoe. "The litigation motive, and not the quality of care, is the real cause of all litigation."

Most lawsuits are filed in metropolitan areas, the centers of medical care, according to Griffin.

"Do you mean to tell me the care delivered in the counties outside those centers is so much better than the medical care delivered in the metropolitan centers of education?" he asked the audience incredulously.

He answered his own question by suggesting that the reason lies with the preponderence of lawyers in urban areas, "all looking to keep themselves going," and with the pervasive urban greed for "something for nothing."

Structured awards

He recommended that those concerned try revising the malpractice system by working for structured awards in lawsuits, and by doing away with windfall settlements.

"How much does an individual need to cover his future medical bills to age 65, and future loss of wages? A jury could decide that," he said to the group.

What happens under a no-fault malpractice insurance system?

"Whether the physician is at fault or not, you're going to give the future costs of all medical care, and their wage losses, to this same societal group that has been looking for a free ride all their lives and insurance companies are going to underwrite what we used to pay Blue Cross Blue Shield, Medicare and Medicaid.

"You have waived your right to contend that the situation was due to the plaintiff's fault.

"What does this do to the doctor's psyche, or to the sense of professionalism?" he asked. "Doctors will stop giving their patients the benefit of the doubt in terms of the quality of care. They will stop giving the little extra time and attention.

"The fear of litigation at least provides an incentive to provide quality care."

Griffin also said he thinks physicians cannot afford to support a no-fault system themselves.

"If patients want to go out and purchase no-fault medical insurance like no-fault auto insurance, fine, let them pay for it. Such a system should not be supported by physicians. There are not enough dollars left in the practice of medicine to pay for this solution.

"If physicians have paid the dollars, they are entitled to say, 'If I screw up, I'll pay; but if I did not cause the problem, I don't owe anything.' And you shouldn't do it."

No guarantee

Griffin pointed out that proponents cannot guarantee the end product of a legislative proposal for a no-fault medical insurance program, and would take a risk in proposing one.

He noted that some states which have a no-fault system set a ceiling on the amount of damages which can be sought through no-fault, and anything over that amount goes to traditional litigation, anyway.

He also reported that in his home state of Pennsylvania, litigation is burgeoning when a physician does not pay what the plaintiff demands. At that point, the plaintiff sues the physician for not acting in good faith, and the case goes to the courts.

He closed by challenging his audience to return home and convince local physicians that the no-fault concept means that "whether they did anything wrong or not, they are going to pay the claim."☐

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Wayne County Medical Society launches case review system

Wayne County Medical Society's Task Force on Professional Liability has chosen to approach the current liability situation by establishing a case review panel system. The following articles describing that approach are reprinted, with permission, from *Detroit Medical News*, weekly publication of the Wayne County Medical Society.

The WCMS Council, at its meeting on October 10, adopted a report and recommendation from the Society's Task Force on Professional Liability to establish a system of case review panels as a new service to the membership. The panel system has been under development by the Task Force for over a year, and periodic progress reports have been presented to the Council, Delegate Body and published in the *Detroit Medical News* for the information of the membership.

The final Task Force report was adopted by the group on September 14 and forwarded to the Council for official Society action. Due to the fiscal note involved, the report will now be considered by the Board of Trustees for funding in the fiscal year 1985 budget.

The Task Force developed the system in full cooperation with WCMS legal counsel, Mr. William Buesser, and in cooperation with representatives of MPMLC, PICOM and Medical Protective. The Task Force felt strongly that this new service to the membership is an important step in supplying support to members who are sued, and in providing an important educational function.

The "Wayne County Medical Society Malpractice Case Review Panel System" shall henceforth be available to active, life and retired members in good standing of the Wayne County Medical Society as a membership service. The purpose of the Case Review Panel shall be to assist Society members who are charged with medical malpractice in the prompt and objective evaluation of those claims; to make available to them qualified experts in cases which are defensible; to promote a better understanding on the part of Society members as to the causes and motives leading to malpractice litigation, and, thereby, to improve the quality of medical care provided by Society members.

Here's how it works

Preamble

The "Wayne County Medical Society Malpractice Case Review Panel System" shall henceforth be available to active, life and retired members in good standing of the Wayne County Medical Society as a membership service. The purpose of the Case Review Panel shall be to assist Society members who are charged with medical malpractice in the prompt and objective evaluation of those claims; to make available to them qualified experts in cases which are defensible; to promote a better understanding on the part of Society members as to the causes and motives leading to malpractice litigation, and, thereby, to improve the quality of medical care provided by Society members. The Case Review Panel System shall be available in lawsuits arising out of claims of medical malpractice, breach of contract, libel and slander, and alleged failure to obtain informed consent which arise out of the practice of medicine. Panel Reviews shall not be available for claims which are not insurable risks under standard professional liability insurance policies.

Procedural Outline

1. Following the service upon the physician member of suit papers, the member, through his attorney, may request a Panel Review. In all cases, the request shall be submitted by the physician's attorney in writing. The written request shall verify that the attorney has been authorized, by both the defendant physician member and his insurance carrier if any, to request a Panel Review and shall be in the form attached hereto. A copy of the Summons and Complaint shall be attached to the written request. Further information as to the nature of the claim shall be submitted to the physician members of the Panel only, and not to the Society.

2. Defense Review Panels shall if possible, consist of three physicians from appropriate specialty areas.

3. The *Medical* Society shall

Continued on Page 89

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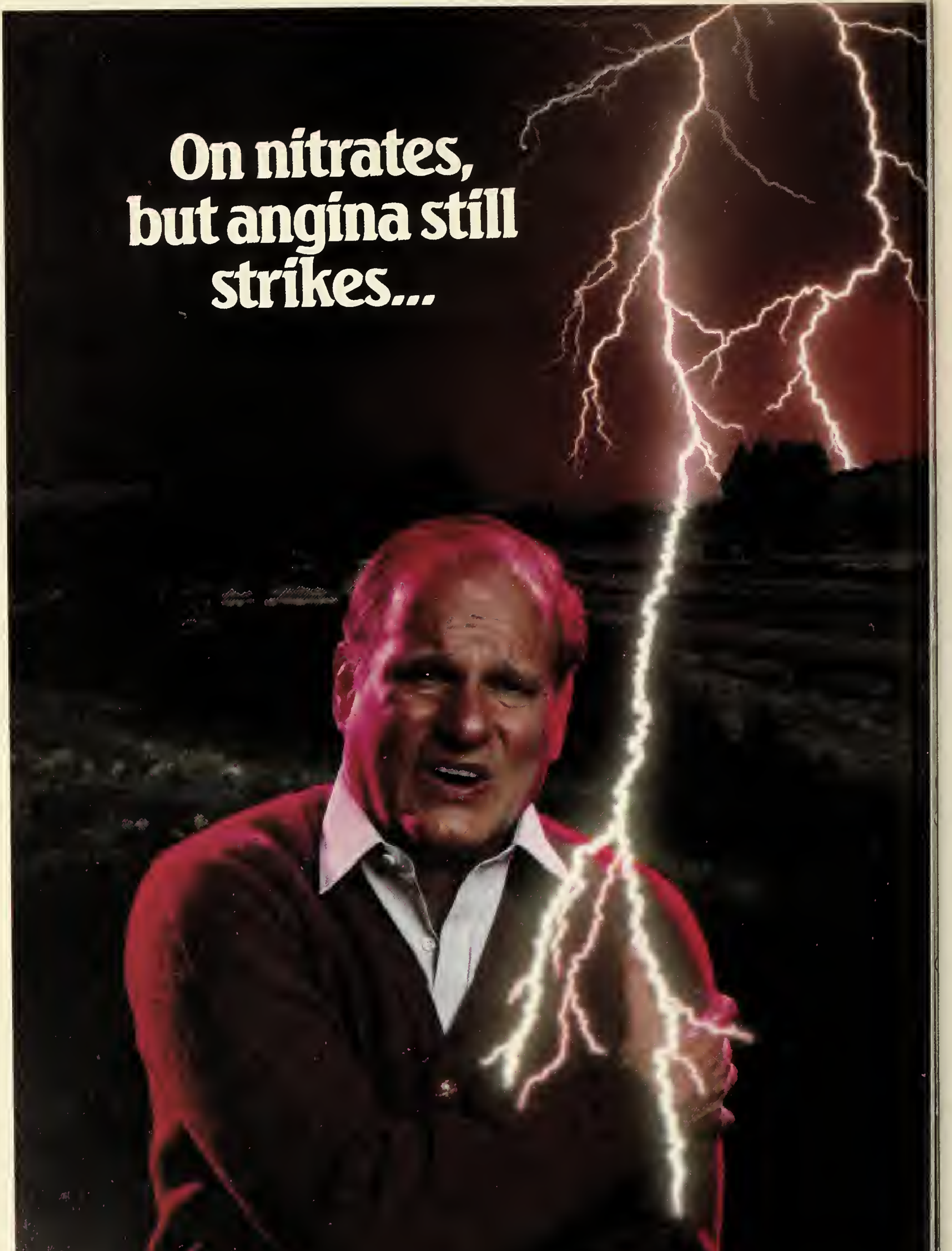
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CMS panels/Continued

mpile a list of its *physician* embers to serve as Panel memrs. Upon recipt of a request for case review, the Society shall signate three physicians as nel members on a "blind draw" sis drawn by lot from the availle list. The Society shall then tify the attorney who has reested the review on behalf of e defendant member of the me or names of the proposed nel members. The physician, s attorney and/or his insurance rrier shall each have the right reject any proposed Panel ember. Only upon receipt of authorization on the form from e defendant physician memr's attorney indicating that the ysician member and his insurce carrier, if any, the physician's torney, shall send a notice of e Panel meeting to the Panelember(s) and to the physician ember and his legal representives.

5. The Panel shall convene at e Wayne County Medical Sociy Headquarters building at the ne and date indicated in the eeting notice or at such other ace as may be agreed upon.

6. The Panel is to provide an curate and objective appraisal d evaluation of the facts in the se.

7. If the Panel determines that e case is defensible, the Panel embers agree to act as witesses for the defendant physan member. The physician ember shall retain the right to mploy and consult with other ysicians as experts in the dense of his case. If the Panel recommends that the case is not defensible, the work of the Panel is concluded.

8. The Panel member or members shall not prepare a written report unless and until one is requested in writing by the physician member's attorney.

9. Panel members shall receive no compensation for their initial review of the case. However, in the event the Panel members are asked to prepare a written report, or to testify at deposition or trial, or to provide further reviews and analyses of the case, that shall be compensated in accordance with local custom and practice.

10. The Wayne County Medical Society shall assume all expenses associated with compiling lists of proposed Panel members, selection of Panel members, and the scheduling of Panel Reviews, but will not assume any other costs, fees or expenses, including compensation to Panel members.

11. Panel hearings shall be attended by the defendant member, his attorneys, representative of his insuarnce company, if any, along with the volunteer members of the Panel. No Wayne County Medical Society staff will attend the Panel hearings. At the conclusion of Panel hearings, all records and written material concerning the claim shall be returned to the physician member and/or his attorneys.

12. The Society and/or counsel for the physician member shall provide legal counsel and support for all Panel members in the event he/she is subpoenaed for deposition or otherwise contacted by the plaintiff's attorney.☐

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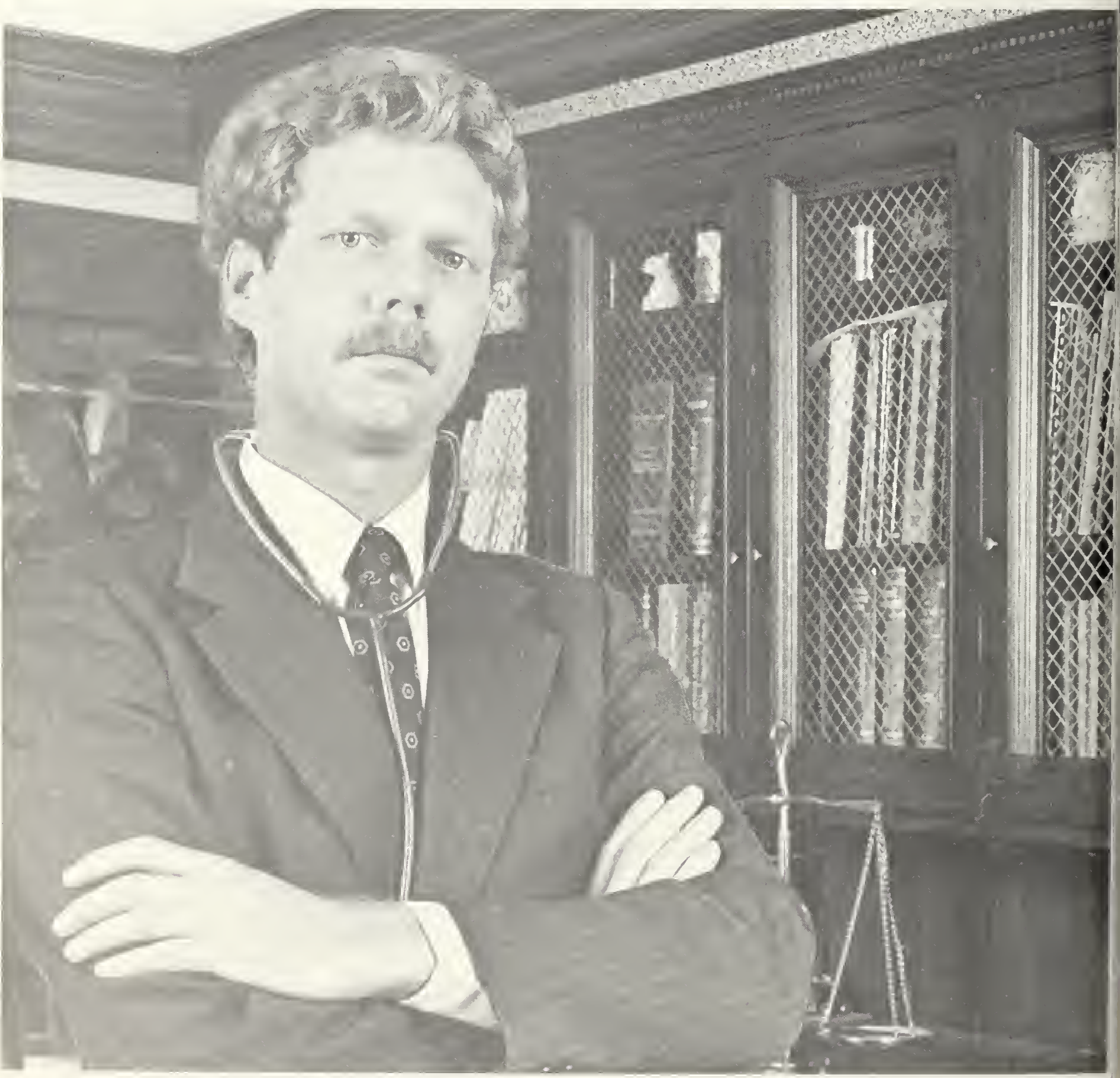

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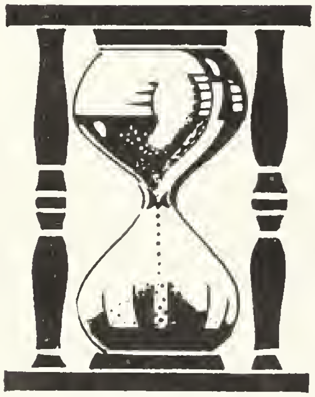
By Daniel G. Beyer, JD

When does a wrongful death claim die of old age?



Attorneys are often confronted with the question of when a claim based on the wrongful death of a patient is barred by the delay in filing the claim with a court. This is part of a concept known as the statute of limitations. Statute of limitations provisions govern all claims that may be made against persons or corporations, including claims based on contract, personal injury, libel, slander or any other case where money damages are sought.

This article will discuss some of the issues which arise in malpractice cases when the claim is based on the wrongful death of a patient. The issues concerning the statue of limitations in malpractice actions are complicated and they all cannot be discussed in full here. This article will concentrate on wrongful death cases, because it is those lawsuits in which the potential for high jury verdicts is often greater than usual.

- *The statute normally requires the claim to be filed within two years from the last date of treatment and/or six months from the date the malpractice should have been discovered, whichever is later.*

The Michigan statutes state the general proposition that a lawsuit based on malpractice must be filed by the date not more than two years after the last date of treatment or service applicable to the matters "out of which the claim for malpractice arose". This statute calls for the filing of a lawsuit within two years of the last day the doctor saw the patient. However, this rule can be modified by the "discovery plus six months" rule. That provision can allow the plaintiff additional time to commence an action more than two years after the date of last treatment because it authorizes the plaintiff to file a complaint within six months after he or she discovers or should have discovered the existence of the claim. This statute was enacted because of perceived inequities involved in certain cases, such as when a surgeon mistakenly leaves a sponge or tool inside a patient and the patient may not manifest any physical complaint until months and perhaps years later. Because medical malpractice claims involve physical manifestations that are not always readily apparent at the conclusion of treatment, the Michigan Legislature decided to create thi provision which, under proper circumstances, would enable a claim to be brought more than two years after the last date of treatment or service.

The Michigan Court of Appeal has wrestled with this concept with no real success for the last ten years or so. A thorough analysis of the "discovery plus six months" rule alone would be sufficient for an article. However a basic understanding of that statute is necessary for physicians in Michigan to understand when claims might be viable against them in wrongful death actions.

- *Plaintiffs have more time to file wrongful death actions.*

Before one attempts to understand Michigan law concerning the statute of limitations issues, there must be some understanding of a legal doctrine known as "tolling". The statute of limitations period applicable to a particular wrongful act (known as a "tort"), generally starts running on the date the to

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Mr. Beyer is an associate with Kerr, Russell and Weber, MSMS legal counsel.

Continued on page 9

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occurs or, in malpractice cases, on the last date of treatment. However, the concept known as tolling *delays* the date the particular statute of limitations period starts running. It is this tolling concept which the Michigan Supreme Court recently discussed in *Hawkins* v *Regional Medical Laboratories, P.C.*, which has created the confusion and perhaps, inequity, in applying the two-year statute of limitations to wrongful death cases based on alleged medical malpractice.

Personal representative

In short, the statute of limitations (two years) does not start running until a personal representative is appointed for the estate of the deceased patient. This will be discussed in detail in the following paragraphs, but you can already see that if there is a delay in opening up the estate of the deceased patient, the claim remains a dormant one and the limitations period does not start to run until that administrative act is done by the probate court.

The facts in *Hawkins* bear some repeating because of the analysis used by the court in deciding the case. The claim was based on the defendants' failure to diagnose a malignant carcinoma. Mr. Hawkins' last treatment was on April 29, 1975 and he died on January 27, 1976. The last treatment was not instantaneous with the death of the patient, and this was an important factor in the court's analysis. The complaint was filed on January 6, 1978, more than two years after the last date of treatment but less than two years after the date of death.

The court made a landmark ruling and decided that, based on one of the Michigan death statutes, the two year statute of limitations does not commence running from the last date of treatment, but from the date the personal representative is appointed, assuming the patient dies within two years of the last treatment. The court decided that because the underlying liability theory was based on malpractice, the two year statute of limitations governing malpractice actions would apply. The record did not indicate when the personal representative for the estate of Mr. Hawkins was appointed, but that fact was not necessary because the complaint was filed within two years of the date of death and even if the personal representative had been appointed on the same day as Mr. Hawkins died, the cause of action would have been filed on time. However, *Hawkins* also held that in no instance can the cause of action be commenced after three years after the period of limitations has run. Thus, assuming the patient dies within two years after the last date of treatment, and no personal representative is appointed before three years after the date of death, the complaint can only be timely filed if it is done five years after the last date of treatment. Thus, if the last day of treatment is December 1, 1983, the patient dies January 1, 1984, and no personal representative is appointed until some period after January 1, 1987, the cause of action could be brought as late as December 1, 1988 and not be barred by the statute of limitations. If the lawsuit is filed after that date, the plaintiff still may have an argument that the malpractice was not discovered until six months before the complaint was filed, but this argument would become weaker and weaker as time progresses.

Critical date

It is thus obvious that the critical date is the date the personal representative is appointed. I recently had the opportunity to analyze the *Hawkins* rationale in a case pending before the Macomb County Circuit Court. In that case, the plaintiff's widow filed a lawsuit based on the claim the doctor failed to diagnose an impending heart attack. The last date of treatment was November 12, 1979 and the patient died two days later on November 14, 1979. The estate was opened on March 12, 1980, just about four months after the death. I argued that the complaint had to be filed before March 12, 1982, or it would be barred by the statute of limitations. However, the complaint was not filed until November 12, 1982, and I successfully argued, based on other facts, that the widow knew of the existence of a claim before six months before the lawsuit was filed. The Macomb County Circuit Court Judge agreed, and dismissed the case. The widow is now seeking relief from the Court of Appeals. Again, the crucial fact assisting in this defense was the opening of the deceased patient's estate so soon after his death.

It appears the economic stature of the patient is a very important factor in determining when the claim would be barred due to the lapse of time. If the patient is a wealthy person, it is more likely the estate would be opened sooner after the death to facilitate the administration of the assets to the patient's heirs and legatees. However, in the case of an indigent person or one without means, personal representatives often are not appointed at all. But a personal representative must be appointed to prosecute any civil action, including a malpractice action, and in many cases, this appointment is not made until the widow or other family member contacts an attorney to discuss the possibility of filing a malpractice claim. This may not occu until months or even years after the death. Should the attorney believe a viable malpractice claim exists, the estate would then be opened by the appointment of the personal representative. The two year period then commences running from that date but remember, no Complaint can be timely filed more than five years after the date of last treatment.

Limitations rationale

Why is there the distinction in limitations periods, due to tolling between normal malpractice cases and wrongful death cases

Continued on page 9

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The rationale is based on the proposition that when a person dies, one of the basic sources of information concerning treatment is lost. The decedent's affairs are, for the most part, put in limbo until a personal representative is appointed to handle the assets of the estate. A cause of action is deemed an asset of the patient's estate and therefore, the management of that asset cannot be properly handled until a personal representative is appointed to do so. The legislature and Supreme Court have mandated that the two year limitations period should be delayed until someone is technically in charge of handling that particular asset, the potential lawsuit.

Another difficulty in analyzing this issue is determining whether or not the death was instantaneous. In *Hawkins*, the decedent's death was clearly not instantaneous with the last treatment. Recently, the Court of Appeals analyzed this issue in *Ortiz* v *Ferris*. In *Ortiz*, the patient died on April 29, 1976 following surgery done earlier that day. This was obviously the last date she was treated by the defendant physicians. On February 15, 1979, a Personal Representative for her estate was apppointed (note the long tolling period here) and on April 27, 1979, just a couple of months after the personal representative was appointed, a lawsuit was filed. The lawsuit was filed more than two years after the last date of treatment but much less than two years after the personal representative was appointed. The physicians' attorneys argued that because the patient died on the last date she was treated, the death was instantaneous and, therefore, the *Hawkins* rule that the commencement of the two year limitations period be tolled until the personal representative was appointed would not apply. They argued that the two year period began running at the time of the last treatment and "instantaneous" death.

The Court of Appeals held that the record was not clear because it could not be determined whether the patient lingered on for several hours after last being seen by the defendants and, therefore, the fact that the patient died on the last day of treatment did not necessarily mean the death was instantaneous. The Court of Appeals held that the two year rule applies in the instantaneous death situation and sent the case back to the trial court level for a determination whether the death was *in fact* instantaneous.

Semantics

Although the language of *Ortiz* seems to suggest the statute of limitations could be drastically shortened if the death was instantaneous, is there ever an instantaneous death in a cause of action based on malpractice? The very nature of the claim has to be distinguished from a motor vehicle or products liability case, where a person's life can be extinguished instantaneously in a car collision, construction disaster or industrial accident. Absent the situation such as where a surgeon takes the blade and jams it into the patient's heart, it would seem there would be almost no cases where the death would be instantaneous with the last treatment. Thus, the possible reduction of the statute of limitations to a "pure" two year standard without any tolling until the date the personal representative is appointed is largely illusory.

What if the patient dies more than two years after the last date of treatment? In such a case the *Hawkins* analysis should not apply. In that case, the patient's cause of action would be two years old and he would still be alive then. The lawsuit would have had to have been filed by that time. The fact that a patient dies after the limitation period ends does not preclude a claim by the estate for pain and suffering and other damages that accrued before the patient's death. In other words, the lawsuit that would be filed would not be technically a wrongful death action, (because the patient was alive two years later) but rather a cause of actic based on damages sustained b fore death, with additional claimed damages after the deat Damages arising from the wron ful death could be claimed anyway, because if the lawsuit was properly filed within two years of the last date of treatment, it would be filed timely in any ever death or not. If the complaint w filed more than two years after the last date of treatment wher the patient died more than twc years after the last date of trea ment, it would seemingly be ba red because it was not filed with the two year limitations period.

Remember, in *any* case the plaintiff can claim that the claim was not "discovered" until a ce tain point in time, and that the complaint was filed within six months of that date.

- *Can the physician anticipa what limitations period will app in a particular case?*

As is so often the case in ad vising clients, the answer is no, there is no real set rule that car be applied in every case. The "discovery plus six months" rule wreaks havoc in almost any cas which is clearly filed beyond the two year period, whether the tw year period is tolled or not. Leg technicalities often create inequities which do not rise to th level of unconstitutional unfairness or a violation of any one group's rights. Why should ther be a distinction on whether the death was instantaneous or not Is it fair for socio-economic factors to play such an important rule in determining when the tw year limitations period starts rui ning? Given the same set of fact why should the widow who de lays in opening the estate of he deceased husband in effect be rewarded by that delay?

This article is not designed tc comment on the moral determ nation of these questions, or eve attempt to answer them. It is merely an attempt to illustrate th issues that confront the physici and his or her counsel in defending lawsuits on the basis th complaint was filed too late.☐

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Please see following page for Brief Summary.

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Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention, these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis

Precautions: *CNS Effect* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment In long-term use, precautions should be taken to avoid increases in dose by the patient *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting *Drug Interactions Usage with Alcohol* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed *Pregnancy Category C* Should be given to pregnant women only if clearly needed *Labor and Delivery* Use with caution in women delivering premature infants Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown *Nursing Mothers* Caution should be exercised when administered to a nursing woman *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope *Respiratory* Rarely, respiratory depression *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora *Ophthalmic* Visual blurring and focusing difficulty *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia *Other* Headache, chills, insomnia, weakness, urinary retention

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance

Dependence and withdrawal symptoms have been reported with orally administered pentazocine Patients with a history of drug dependence should be under close supervision Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx

The amount of naloxone present (0 5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine, however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated Assisted or controlled ventilation should also be considered For respiratory depression, parenteral naloxone is a specific and effective antagonist

Please consult full product information before prescribing

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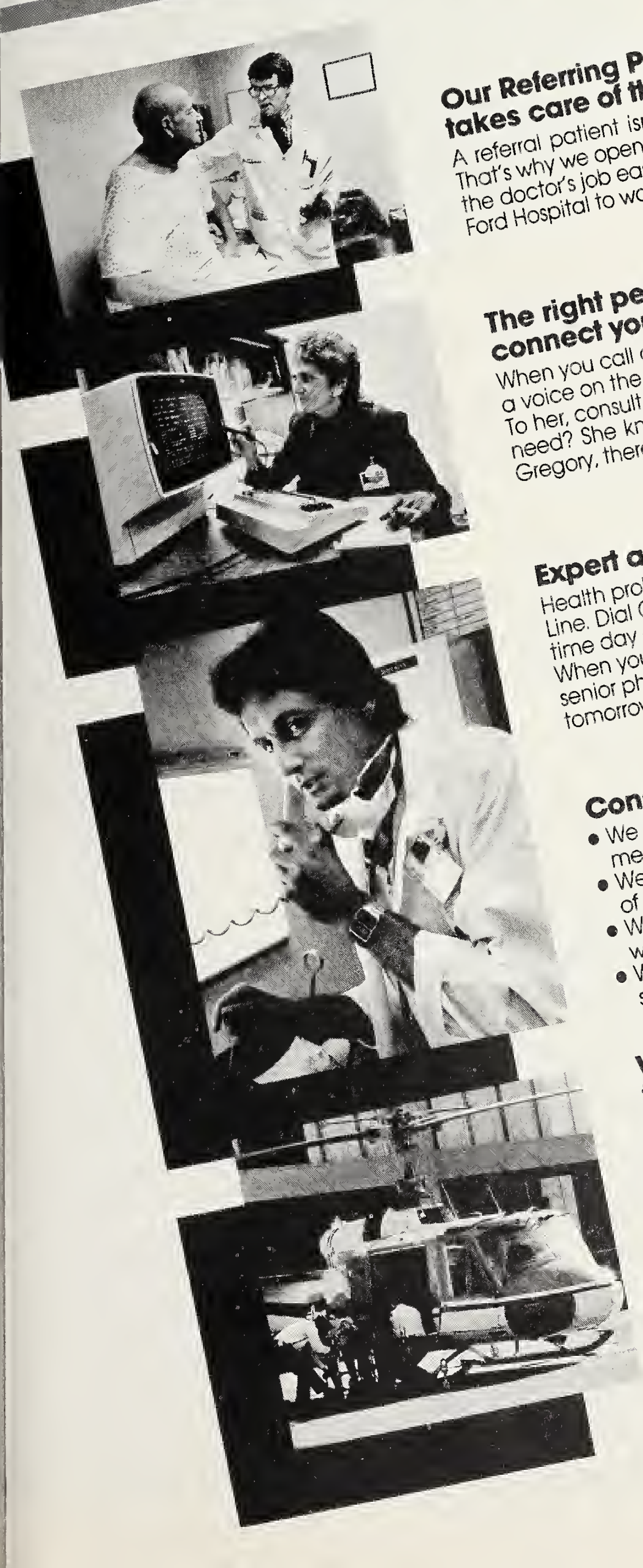
Henry Ford Hospital

Referring Physician Office

- ■ To consult with a physician or arrange patient transport, call **24 Hour Consult Line: 1-800-662-8242**
- ■ For general information call Ardis Gregory at **Referring Physician Office (313)876-1461**



Board of Medicine proposes new amphetamine rules

New rules affecting the standards of practice regarding sympathomimetic amine drugs, including amphetamines, have been proposed by the Michigan Board of Medicine. The amended wording of the rules, printed below, is expected to be accepted by the Board in mid-March, given to the Governor for approval, then filed with the Secretary of State.

This rule takes effect 15 days after filing with the Secretary of State.

(By authority conferred on the board of medicine by section 16145 of Act No. 368 of the Public Acts of 1978, as amended, being 333.16145 of the Michigan Compiled Laws)

R 338.2303 of the Michigan Administrative Code, appearing on pages 508 and 509 of the 1981 Annual Supplement to the 1979 Administrative Code, is amended to read as follows:

PART 1. GENERAL PROVISIONS

R 338.2303 Standards of practice regarding **sympathomimetic amine drugs, including** amphetamines.

Rule 3. (1) **The Board of Medicine has determined that any of the sympathomimetic amine drugs, except dextroamphetamine, designated in schedule 2 under the code or the rules promulgated by Michigan's Board of Pharmacy, have negligible therapeutic value, have a high potential for physical and psychological addiction, have serious detrimental health effects when abused, are widely abused through intentional or misinformed acts in the medical and lay communities, and pose a health hazard and risk for improper medical treatment vastly disproportionate to any legitimate use of such drugs. The board has further determined that there are alternative treatment modalities to such drugs of at least comparable therapeutic value which do not pose similar risks. In accordance with these determinations, and except as provided in subrules (4) and (5 of this rule on the prescribing of dextroamphetamine, and selling, prescribing, or administering of any of the sympathomimetic amine drugs designated in schedule 2 unde the code or the rules promulgated by Michigan's Board of Pharmacy, constitutes a depar ture from, or failure to confor to, mimimal standards of acceptable and prevailing medica practice.**

(2) Except as provided in sub rules (4) and (5) of this rule o the prescribing of dextroamphetamine, and except a provided in subrule (6) of this rule, the giving, selling, prescribing, or administering of an of the sympathomimetic amin drugs designated in schedule under the code or the rules promulgated by Michigan's Board of Pharmacy is prohibited.

Continued on page 10

Michigan Conference
on Maternal and
Perinatal Health

March 20-21, 1985
Hyatt Regency Dearborn

"Maternal/Perinatal Health:
A Delicate Balance"

For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

(3) A violation of this rule constitutes a violation of section 16221 (a), (b) (i), (c) (iv), and (g) of the code.

(4) Recognizing that dextroamphetamine is therapeutically effective in the treatment of hyperkinetic children, a physician may, by issuance of a written order for dextroamphetamine, prescribe dextroamphetamine for a hyperkinetic child, if the physician, before writing a prescription for dextroamphetamine, has done all of the following:

(a) Taken a complete history?

(b) If the child is attending school, secured a report from the child's school regarding the child's current and past behavior.

(c) Completed a physical examination, including a neurological examination.

A prescription for dextroamphetamine ordered for a hyperkinetic child shall indicate on the prescription order, in the physician's own handwriting, the purpose for which the drug is being prescribed.

(5) Recognizing that dextroamphetamine is therapeutically effective in the treatment of narcolepsy, a physician may, by issuance of a written order for dextroamphetamine, prescribe dextroamphetamine for narcolepsy, if the physician, before writing the prescription for a patient, secures a waiver of this rule from the board. The application for the waiver shall include both of the following:

(a) A complete history and physical examination, with appropriate studies of the patient for whom the waiver is being requested, establishing that the patient suffers from narcolepsy.

(b) The written concurrence of another physician in the diagnosis and prescribing of dextroamphetamine for the patie involved.

A prescription for dextroamphetamine ordered to treat narcolepsy shall indicate on the prescription order, in th physician's own handwriting, the purpose for which the dru is being prescribed.

Recognizing the need for innovative medical practices and the unpreductability of scientific developments, a physician may apply for a written waiver of th requirements of this rule by sub mitting a written request to the board. The request shall include all information necessary for a comprehensive evaluation of its merit. If the physician requestin the waiver demonstrates to the satisfaction of the board that a waiver would further legitimate medical purposes without undermining the purposes of this rule, the board may issue a wri ten waiver with such terms and conditions as may be deemed appropriate.☐

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By Judy Marr, Edito

Maternal/perinatal health conference will examine ethics, science

The ethical dilemmas posed by today's obstetrical developments will be highlighted at the 1985 Michigan Conference on Maternal Health, March 20-21 at the Hyatt Regency Dearborn.

Registration forms for the conference appear in the January issue of *Michigan Medicine* and in the January 17 issue of *Medigram.*

Co-chairmen Rudi Ansbacher, MD, Ann Arbor, and Robert W. Dustin, MD, Dearborn, urge MSMS members to register soon for the conference, which annually attracts 1,000 Michigan physicians, nurses, students and others.

Ethical and psychological topics to be covered include:

"The Nurse/Physician Relationship"— Relationships between nurses and physicians have become strained in recent years because of changes in the health care system and because of the new roles and expectations of women. Changes in the professional roles of nurses and physicians over the past 50 years will be explored.

"Perinatal Loss — A Multidisciplinary Approach"— Pregnancy loss shatters family dreams. A perinatal support service should provide medical, genetic, and emotional counseling. This presentation evaluates the effectiveness of such a program.

"Ethics in Relation to the Malformed Fetus"— Our increasing ability to identify developmental anomalies before birth, and to perform corrective operations on the fetus has raised many ethical questions. Those practicing obstetrics must develop individualized approaches incorporating family needs and legal and ethical considerations.

"Malpractice in Obstetrics — Legal Aspects"— Avoiding potential litigation by establishing criteria for diagnosis and management options, and by keeping careful records can be accomplished. Cases involving such aspects will be presented.

"Ethical Decisions Related to the Handicapped Newborn"— Dilemmas encountered in dealin with handicapped newborns wil be illustrated by actual cases. Discussion will address the fact that decision-making remains difficult, controversial and open to challenge.

Clinical topics

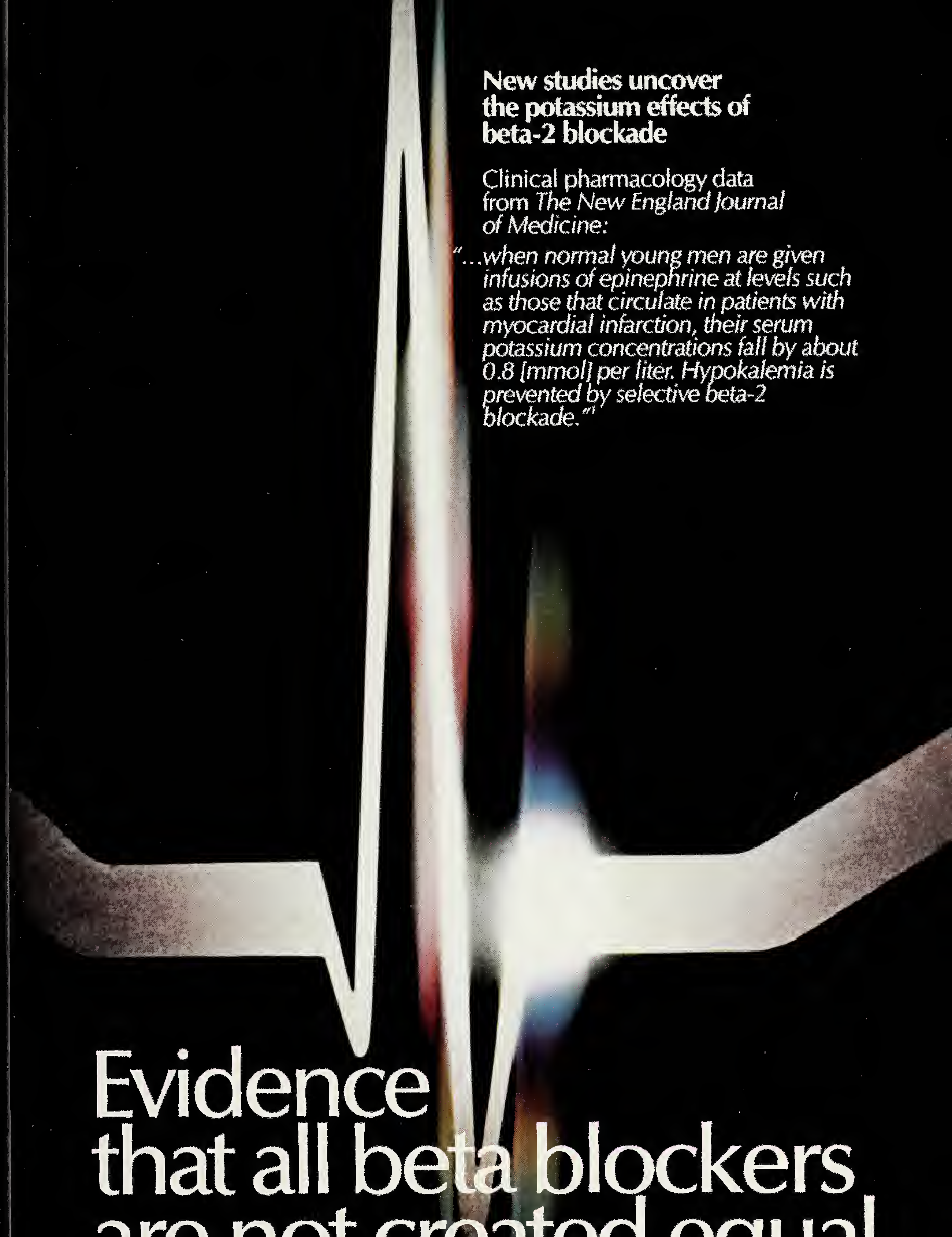
Clinical topics will comprise th bulk of the two-day program, which also features a variety of round table luncheon meetings with the speakers.

Among the clinical presentations will be "Management of Post-Partum Bleeding;" "Neonat Nursing;" "The Addicted Fetus and Newborn;" "The Obstetric Nurse Practitioner;" "Care of the Very-Low Birthweight Infant," from obstetrical, nursing and nec natal aspects, and "Sexually-Transmitted Diseases in Pregnancy."

Others will be "Dermatologic Problems in Pregnancy;" "Molecular Genetics;" "Artificial Surfactant Therapy in Neonatal RDS;" "Catastrophic Inborn Erro of Metabolism in the Newborn; "High Frequency Ventilation;" "Chorionic Villi Sampling," and "Laboratory Diagnosis of Obste ric and Gynecologic Infection."

The Maternal Health Conference is approved for 13 hours of Category I credit. And, the American Academy of Family Physicians has reviewed and approved the program for 13 hou of prescribed credit.

Details on the program, registration and housing arrangemen are available from Sherry Fent a MSMS headquarters.☐



New studies uncover the potassium effects of beta-2 blockade

Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

Right from the start in hypertension…

120
140
160
180
200
100
220
80
240
60
40

Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

AL LA
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80 mg 120 mg 160 mg

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Please see brief summary of prescribing information on the next page for further details.

Once-daily

For beta-1/beta-2 blockade

INDERAL® LA

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

RAL LA
80 mg
RAL LA
120 mg
RAL LA
160 mg

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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibit
receptor agonists and its effects can be reversed by administration of such ag
dobutamine or isoproterenol However, such patients may be subject to protract
hypotension Difficulty in starting and maintaining the heartbeat has also been rep
beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may preve
pearance of certain premonitory signs and symptoms (pulse rate and pressure c
acute hypoglycemia in labile insulin-dependent diabetes In these patients, it ma
difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hypert
Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of
of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid func

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases
reported in which, after propranolol, the tachycardia was replaced by a severe br
requiring a demand pacemaker In one case this resulted after an initial dose
propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients wit
hepatic or renal function INDERAL (propranolol HCl) is not indicated for the tre
hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure
should be told that INDERAL may interfere with the glaucoma screening test Withd
lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe hea
elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs suc
pine should be closely observed if INDERAL is administered The added catec
blocking action may produce an excessive reduction of resting sympathetic nervo
which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or
hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in an
been conducted to evaluate toxic effects and carcinogenic potential In 18-month
both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of
drug-induced toxicity There were no drug-related tumorigenic effects at any of th
levels Reproductive studies in animals did not show any impairment of fertility
attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be emb
animal studies at doses about 10 times greater than the maximum recommended hu

There are no adequate and well-controlled studies in pregnant women INDER
be used during pregnancy only if the potential benefit justifies the potential risk to

Nursing Mothers INDERAL is excreted in human milk Caution should be exerc
INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient
rarely required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV bl
tension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, us
Raynaud type

Central Nervous System lightheadedness, mental depression manifested by
lassitude, weakness, fatigue; reversible mental depression progressing to catato
disturbances, hallucinations, an acute reversible syndrome characterized by disorie
time and place, short-term memory loss, emotional lability, slightly clouded sens
decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting epigastric distress, abdominal cramping,
constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined w
and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombo
purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus
reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, m
tence, and Peyronie's disease have been reported rarely Oculomucocutaneous
involving the skin, serous membranes and conjunctivae reported for a beta blocker
have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydroch
sustained-release capsule for administration once daily If patients are switched from
tablets to INDERAL LA capsules, care should be taken to assure that the desired th
effect is maintained INDERAL LA should not be considered a simple mg for mg sub
INDERAL INDERAL LA has different kinetics and produces lower blood levels Retit
be necessary especially to maintain effectiveness at the end of the 24-hour dosin

HYPERTENSION—*Dosage must be individualized* The usual initial dosage
INDERAL LA once daily, whether used alone or added to a diuretic The dosag
increased to 120 mg once daily or higher until adequate blood pressure control is
The usual maintenance dosage is 120 to 160 mg once daily In some instances a dos
mg may be required The time needed for full hypertensive response to a given
variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg IN
once daily, dosage should be gradually increased at three to seven day intervals unt
response is obtained Although individual patients may respond at any dosage
average optimum dosage appears to be 160 mg once daily In angina pectoris, the
safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a f
(see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg IN
once daily The usual effective dose range is 160-240 mg once daily The dosag
increased gradually to achieve optimum migraine prophylaxis If a satisfactory resp
obtained within four to six weeks after reaching the maximum dose, INDERAL L
should be discontinued It may be advisable to withdraw the drug gradually over a
several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once dai
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age gro
limited to permit adequate directions for use

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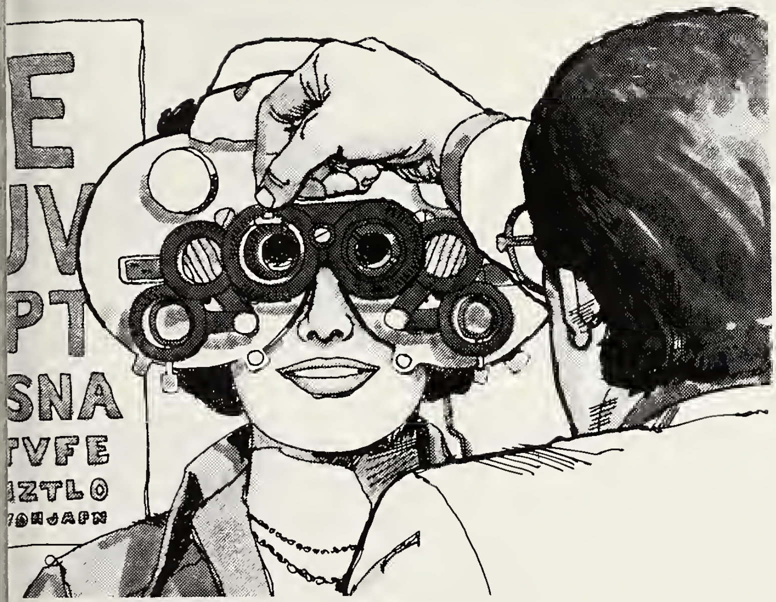

evelopment of the Michigan iabetic retinopathy guidelines

The National Institutes of Health estimates that 5,000 nericans become blind each ar as a result of diabetes. Re- nt research has indicated that ndness due to diabetic re- iopathy may be reduced by as uch as 50 percent with appro- iate screening and early treat- ent of the condition. A 1983 ticle in the *Journal of the nerican Medical Society* called tention to the accuracy of diag- oses of diabetic retinopathy by variety of medical practitioners the University of Pennsylvania. eir work clearly indicated that abetic retinopathy was diag- osed with a significantly greater te of accuracy when the diag- osis was made by opthal- ologists than when made by her medical diagnosticians.

Accordingly, the Michigan De- rtment of Public Health called gether a group of physicians st spring to address the prob- m by producing guidelines for e appropriate screening of ople with diabetes for diabetic tinopathy. This group included: ederick W. Bryant, MD; Robert Frank, MD; William H. Herman, MD; Ronald Klein, MD; Raymond R. Marghario, MD; Martin E. Pearlman, MD; Lawrence I. Rand, MD, and Patrick L. Murphy, MD. Six of these physicians were retinal specialists, one was a general opthalmologist, and the eighth represented the interests and involvement of the Center for Disease Control.

The guidelines prepared were then presented to a task force, in June, 1984, whose members represented various health care organizations. These organizations included the Council of Medical School Deans, The Medical Association of Osteopathic Physicians and Surgeons, the Michigan Diabetes Research an Training Center, the Michigan Opthalmological Society, the Michigan Society of Internal Medicine, the Office of Health and Medical Affairs, the Association of HMOs in Michigan, the Michigan State Medical Society, the Michigan Chapter of the Academy of Pediatrics, and the Michigan Optometric Association. Doctor Ronald Klein returned as a consultant for the task force from the department of Opthalmology at the University of Wisconsin. The results of that meeting were that 1) these guidelines that follow represent the state-of-the-art for appropriate referral of people with diabetes for diagnostic examination in relation to diabetic retinopathy, and; 2) the task force participants would approach their various organizations' boards regading formal endorsement and dissemination of the guidelines.

The task force concluded that the Michigan diabetic retinopathy guidelines are appropriate recommendations for referral of people with diabetes for diagnostic examination by ophthalmologists. It is the intent of the Michigan Department of Public Health that these guidelines be brought to the attention of physicians and other health care providers, health educators and people with diabetes, in hopes of reducing blindness in Michigan caused by diabetic retinopathy.

A free copy of the new guidelines, including bibliography, is available by writing Laurie Swick at MSMS headquarters.☐

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- **Endocrine Paraneoplastic Syndromes**
  William D. O'Dell, MD, PhD, chairman, Department of Internal Medicine; professor of medicine and physiology, School of Medicine - University of Utah; Salt Lake City, Utah
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  Stanley Order, MD, director of radiology and oncology - Johns Hopkins Hospital; Baltimore, Maryland
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  George R. Prout, Jr., MD, F.A.C.S., chief, Urological Service - Massachusetts General Hospital; Boston, Massachusetts
- **Historical Perspectives in Cancer Management**
  Juan A. del Regato, MD, veterans administration distinguished physician, Department of Radiology - James A. Haley V.A. Hospital; Tampa, Florida
- **Modern Day Management of Ovarian Carcinoma**
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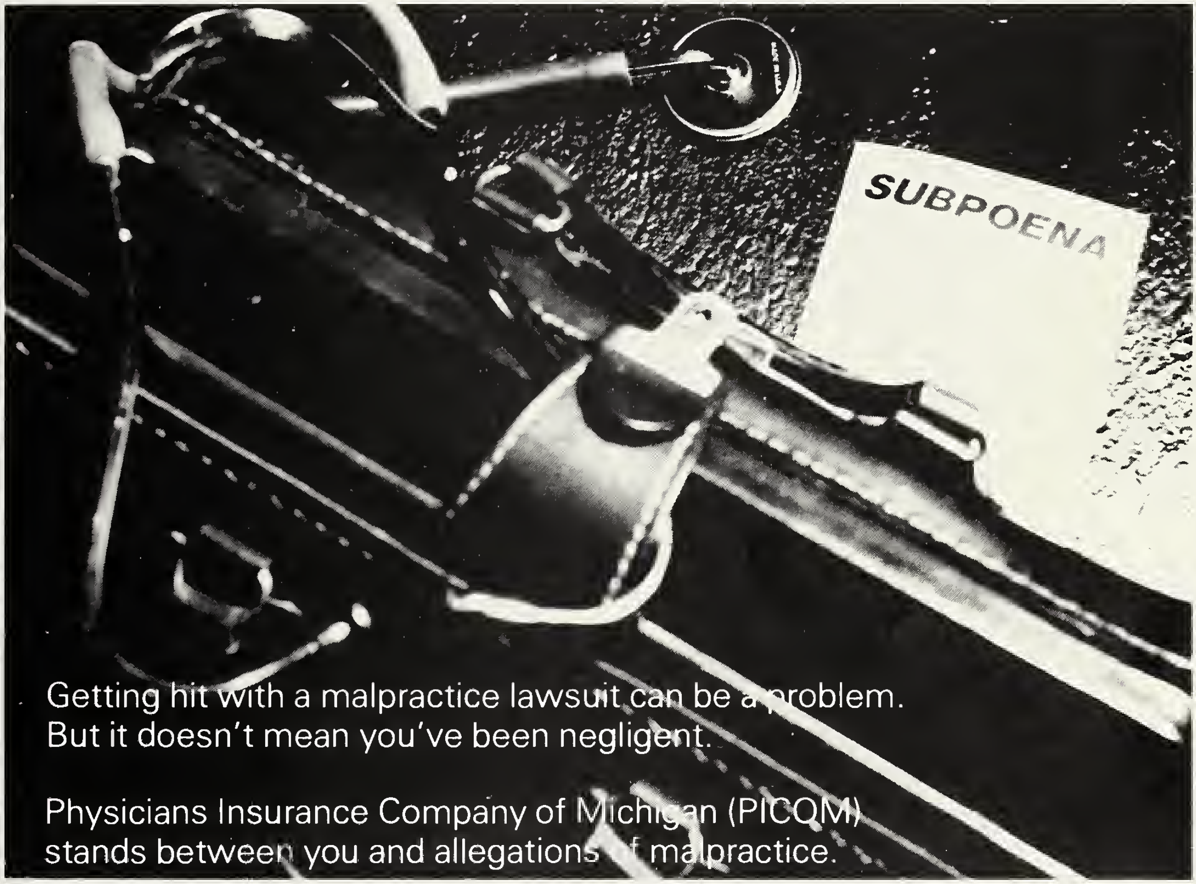
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Pertussis vaccine risks

15 million doses of DTP and 12 million oral polio doses are given to American children each year. Even with the proper administration and the use of the best vaccine products available today, these vaccines present certain irreducible risks. Pertussis vaccine produces higher reaction rates than other vaccines, but Pertussis the disease produces ten times the rate of brain damage as Pertussis the vaccine. These reactions occur at no fault on the part of the physician or the producer of the vaccine.

Neurological complications of P/DTP vaccines include brain damage, death, encaphalitis and convulsions. Pertussis immunizations should be deferred in children who have had a personal history of convulsions, and in children with certain neurologic conditions such as tuberous scleroses and some inherited metabolic defects.

Pertussis, once given, should not be continued if any of the following occur: severe neurologic reaction; persistent unconsolable screaming for three hours or more; a hyporesponsive, shock-like state; temperature of 40.5 C (105 F) or greater, unexplained by another cause within 24 hours following immunization; or an allergic reaction to the vaccine.

Diet, cancer link growing

Several organizations have now concluded that scientific data on the relationship between diet and cancer are strong enough to warrant the development of dietary guidelines to lower cancer risk according to Doctor T. Colin Campbell, Senior Science Advisor to the American Institute for Cancer Research.

To date, the available data "strongly suggest that a diet enriched in plant products reduces cancer risk," said Doctor Campbell, a cancer researcher and professor of nutritional biochemistry at Cornell University. Cancer risk, he said, "increases with high intake of dietar fat and protein, and low intakes of food rich in vitamin C, vitami A (as beta carotene), vitamin E and dietary fiber."

Doctor Campbell's status report on diet, nutrition and cance summarized the studies that hav been undertaken since the first major conference on the subjec was held in 1975. One of the most exhaustive of the studies, completed by the U.S National Academy of Sciences in 1982, found enough of a link to "formulate interim dietary guideline that are both consistent with good nutritional practices and likely to reduce the risk of cancer," said Doctor Campbell, who served on the NAS committee responsible for the report.

Mike
STREFF

"Comfy?"

Pediatric drug studies

Furukawa et al. at Children's Hospital of Michigan recently "demonstrated" in 40 children, ages 5-15 years, that cromolyn may be as effective as theophylline in chronic treatment of mild to moderate asthma. Compliance was 92-98 percent in both groups. Sensitivity to methacholine in the theophylline group was less severe based on the methacholine tests. Althoug the results indicated no significan differences between the two treatments, the mid-dose theophylline level (10-15 mg/L) used would generally not be considered optimal since trough levels would then be below the minimum therapeutic level (10 mg/L).

Children two to 23 months of age were treated in a double blind fashion with cefaclor 20 mg kg/q12 hours, or trimethoprim (4 mg/kg) and sulfamethoxazole 20 mg/kg/q12 hours for acute otitis media. Sixty-five children were in each group and follow-up visits were made at three to six days, two weeks and four weeks following enrollment. Compliance as monitored and bacteriologi- l analysis performed. Although nical outcomes were similar, AP-SMZ was considered more ficacious because of a better adication of the organisms in- lved.

In six healthy males (20-45 ars), theophylline clearance in- eased by approximately 80% hile on rifampin (600 mg/qd for days). In asthmatic children, ampin may be used in combi- tion regimens with INH for the atment of TB, or with van- mycin for staphyloccocus in- ction. This interaction may be important consideration for ese children. Rifampin has also en reported to decrease cyc- sporine levels.

eye's Syndrome pdate

ice October 1st, the beginning this Reye's Syndrome (RS) re- rting year, two cases of RS ve been reported in Michigan children from two different counties. One of the children died. RS was preceded by a respiratory illness prodrome in both children.

Little influenza-like illness has been reported to us in Michigan yet this season. No influenza virus isolates have been obtained so far by our MDPH virology laboratory. According to the influenza activity at the Centers for Disease Control, most of the influenza-like illness that has occurred so far this seaon in the U.S. is related to type A (H3N2) strains. Type A (H3N2) strains are believed to have caused outbreaks in New York City, Chicago, central Illinois, California and Utah. Some type B influenza virus isolates associated with sporadic cases of influenza-like illness have also been reported in the U.S. In the past couple years, type B influenza virus activity has "built" through the winter months to gradually become the predominant strain in the late winter months.

In the Great Lakes Region, the following states have reported RS cases since October 1, 1984: Illinois - 0; Indiana - 0; Minnesota - 0; Ohio - 1; Ontario - 0; Wisconsin - 0.

Cancer preventatives?

Can vitamin E, beta-carotine and the trace mineral selenium help to prevent cancer? A team of Michigan State University cancer researchers, funded by $453,971 from the National Cancer Institute, will try to find out. Two of the team's objectives are to establish, by analysis, necessary diet levels for selenium, beta-carotine and vitamin E, and to consider the effects of longterm intake of supplemental levels of selenium and vitamin E.

"Despite the inherent toxicity of selenium, definite information on long-term effects of human overexposure is very limited," Nikolay Dimitrov, MD, principal investigator says.

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By Paul D. Rheingold

Plaintiff's lawyer describes a "good" malpractice case

The best time to make a detailed analysis of a medical malpratice case is before suit is undertaken. If you wait to learn at trial that there is no liability or that there is a strong defense, you will have wasted a great amount of time and money. We also have come to recognize that without substantial damages and proof of proximate cause, the plaintiff's lawyer will come to grief. No one wins when a $100,000 case is compromised for $10,000.

Beyond these fundamental considerations, however, lie some methods of distinguishing the potentially good case from the bad one. These arise from experience in preparing and trying malpractice cases. Two methods are to analyze the motivation of the client to sue and to analyze those sets of facts that bend a case toward better chances of winning or bear the seeds of destruction.

Client motivation

More than in any other field of litigation, in a medical malpractice case the motivation of the client is crucial to the outcome of the suit. It is inevitable that juries look to the plaintiff's underlying emotions to help decide liability and set damages in these cases. Motivations also predict how well you and the client will get along and whether the client will ever be satisfied with the case, no matter the outcome. If you hear a prospective client say any of the following things, watch out.

- "Those butchers killed my dad. Now I want to get them." Although human, the revenge motive is particularly bad justification for a suit. This client would not be happy even with the doctor's electrocution. You have to explain that tort damages suits are not established to seek the social benefits that the client thought would be there.
- "The doctor has sued me for his $800 bill. I want to counterclaim for all he's worth." This is the person you should stop at the door. If this client had a good case, he or she would have seen a lawyer before the doctor sued on his unpaid fee. The jury is going to perceive what is in fact involved: a cheap client who does not want to pay the bill.
- "Please put my case into suit. The statute of limitations runs in five days." Here is another person to stop at the door. An interview will reveal that he or she has been to see many lawyers, all of whom have turned down the case but considerately have told the prospective client when the statute will expire. The odds are overwhelming that the case is not a good one. If you show any interest, you may be in the position of having to file suit in a rush - and then seek to be relieved by the court.
- "I want you to take over my case. My first lawyers are bums." Beware. If you think that you will appear to be any better than the client's last lawyer ("He would never call me back. He was abusive. He probably sold out to the doctor's lawyers."), you have a lot to learn.
- "I had a bad result. It must have been the doctor's fault." I don't know how many times I have tried to explain to angry clients the difference between liability and damages. Most eithe don't understand or don't want to understand. Trying to tell a seriously injured person that there must be a proximate relationship (I use the term "bridge") between their injuries and some departure on the part of the doctor goes in one ear and out the other. Yet, if that's the analysis, there's no case and the

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lient should be turned away.

- "I rang the call button all ight, and no one responded." his client should never have gotten in for an interview, but if he r she is there, you are going to ay, "And then what happened?" eplies the client, "You don't nderstand. What if something ad happened!" This client has be taught that malpractice neans both fault and injury.

- "I still like Doctor Smith. He as our family doctor for years. ut my children keep telling me should sue." This client lacks the aying power for a long malractice suit. A person has to ave some anger and let it show the proper time. After awhile, omplacent clients will tell you ey want to forget the suit.

- "I want you to sue Doctors nes and Bones, but please leave r. Smith out of this. He was nice me in the hospital." This client ends two shivers down my ine. First, these are decisions at are ultimately for the lawyer make. Second, leaving out one efendant will lead to the sued efendants ganging up on the nsued one after the statute has n. It is essential to have control ver the case. If that can't be acepted, then the client should ok elsewhere for a lawyer.

- "I had this tumor for three onths and the doctor didn't disover it was cancer." Cancer percharges an already emonal malpractice case. Most of ese unfortunate victims are rey complaining about the bad rds fate has dealt them, but you n't sue fate, so the anger is nsferred to the doctor. Somenes the doctor has delayed properly in diagnosing and eating cancer with proximate mages, but often the doctor's elay is minimal at most and not e cause of what followed. If the ctor is being blamed irrationy, you know who is next in line be blamed.

- "Nobody knows how I suffer. y life is destroyed." I do not nt to be cynical about this ent, because one hears this ost of the time. The injuries used by the malpractice, be ey big or small, devastate some clients. They live in pain; their life is abruptly changed. But if these whiners make a bad impression on you will they not turn off the jury too?

Unlike some of my other hypothetical clients, the whiner is one you ought not reject. Even though you know that you will have continuing personality problems with this type of person, I believe you owe him or her representation. After all, it is likely that their genuine pain contributes substantially to making them as they appear to you. It is up to you to make the jury understand that a personality change is yet another inflicted by the doctor's negligence. "Lightly he bears his client's cares" would be a good saying for every plaintiff's malpractice lawyer (and perhaps for every lawyer) to put on a wall. It might serve to remind us all that we are getting paid to care, as well as produce results.

Then the good ones

What then, I can hear you asking, makes a good client? Here is my ideal client talking: "I really don't know if this is a malpractice suit or not. I know I've been injured, but I have to leave it up to you to find out whether the doctor is liable. If you find there is a basis for suit, please sue the parties you think are responsible. Meanwhile, I am going to try to return to work, even without my right leg." (By the way, I am still waiting for this person to come in the office.)

Negative factors

After you have analyzed the motive of your prospective client, the next step is to assess the positive and negative factors of the case. Here are some elements that portend a poor legal prognosis for a plaintiff's lawyer.

- Cosmetic surgery. "I wanted a nice-looking nose, and I suppose it's better than it was, but it's not what I had in mind." This is a case every experienced lawyer would flee from, and so will the jury. A juror will think, "I have a big nose or dumpy breasts, and I've learned to live with it. He got what he deserved." And it makes little difference if there is some sort of medical reason for the surgery and that it was not done just for vanity.

- The dentist. The reason he pays low malpractice rates is that he usually wins at trials. Juries just don't seem to care about other people's teeth and gums, and they tend to believe that the second dentist who charged $10,000 to fix up a mess that the "bad guy" dentist did is no more to be believed than the first.

- The psychiatrist. They enjoy virtual immunity (except for sleeping with patients) because there is no standard by which a possible departure may be gauged. How can a jury find that but for improper psychoanalysis my client would have been less mentally ill today than he is?

- Injury to the genitals, anus, intestines or feet. Like the mouth, there are other parts of the body that jurors seem to be uninterested in, if not outrightly offended, if anybody talks about them. If they must decide for the plaintiff, they tend to bring in small damages. And I don't think we need Freud to tell us why, either.

- A sick person who gets sicker. For example, a 90-year-old man with terminal cancer has a FOOB (a fall out of bed). Yes, this is a wrong, but it is more indignity than a situation that will evoke damages from the jury. When the case comes to trial long after the person is dead, the event will seem trivial.

- Delay in diagnosis of cancer. Many of the cancer cases lack merit because there are no damages proximately related to the fault. At one end the person may have lived several years after the tumor was finally removed, with no metastasis. What are the damages occasioned by the delay? At the other end, the testimony may be that the spread had seeded itself before the primary tumor was detectable, again raising the issue of damages. Many cancer cases are meritorious ones, but in more than any other case, they call for lining up the

Continued on page 116

experts before the suit is started.

- Cancer is wrongly diagnosed. "They cut out half of my buttock because they misread the slide and said it was a malignant tumor." The predictable reaction of the jury when they learn that it was only a benign tumor that could have been locally incised is that the plaintiff should be thankful it wasn't cancer.
- Infection of the incision. To lay persons, having an infection develop in the wound after surgery is obvious malpractice. We know, however, that the usual nosocomial infection is unaccompanied by any fault on the part of the doctor or hospital. Of course, there may be a delay in diagnosing the infection, but the usual case is going to be a loser.
- Hepatitis following a blood transfusion. This is an injury without a remedy, as usually there is no fault and few states impose strict liability.
- Lack of informed consent. It was a great battle won when the plaintiff's bar obtained judicial recognition of the duty of doctors to inform their patients about the risks and alternatives to proposed procedures, but a cause of action based solely on want of informed consent almost always loses. This is because the jury believes that a reasonable person (using the objective standard) would have consented if he or she had been told of the specific risk that came to pass. Nevertheless, an informed consent cause of action joined with one for negligence is often a winner: if the doctor wants to say the result was just one of those known results of surgery, then why didn't he warn about it?
- Multiple defendents, all of whom made the same error. Sometimes the same mistake - for example, misdiagnosis - was made by a series of doctors over time. If enough doctors make the same mistake, they tend to create for a jury their own standard of care. How simple could it have been to make this diagnosis if so may doctors missed it, they will ask. While more defendents provide more pockets from which to obtain a settlement, the better case is one-on-one.
- The defendant is from central casting. He looks as if he stepped out of a Norman Rockwell lithograph. He is kindly and sincere. The jury may overlook his lack of medical knowledge and find it very difficult to bring in a verdict against him.
- The case was so good I didn't need to hire an expert. Famous last words. Beware of res ipsa loquitor.

Positive factors

- Brain damaged babies. Juries are unusually sympathetic to a child injured during delivery or soon thereafter. These cases tend to involve the kind of things to which juries pay close attention.
- The doctor was outside his field. He was, for example, trying to treat an infection that should have been handled by an infectious disease expert, but he wanted to keep the patient with the gynecological staff.
- The doctor is not a physician or is practicing in a cultist area. For example, he is a podiatrist or chiropractor or "into holistic medicine." The plaintiff can manage somehow to hold this defendant's conduct to a higher standard set by a physician specialist.
- A healthy person goes in for a test and comes out injured. Some developments, while little more than "bad results," do motivate a jury to make an award, and this is one, because of the surprise nature of the injury.
- Changes made in records or lost records. If you take on a case where the doctor or the hospital changes something in the records, you will need less than the usual quantum of fault to prevail before a jury. The same is true if a record or X-ray is missing. Even a change that the doctor argues was made for a good faith reason or a record lost with an explanation ("fire," "flood" and "robbery" are the big three) will suggest to the jury that there was a guilty motive afoot - and there probably was.
- The doctor is arrogant, alo hostile or coldly impersonal. Th type of doctor, although he or she may be a medical genius i the laboratory, will not sell well with a jury. Another type who gives the defense counsel shu ders is the foreign medical scho graduate who speaks and write in broken English. It is not nice to comment on ethnic matters but how happy the plaintiff's lawyer is when the target is "D Patel," the radiologist from Baluchistan.

Words of caution

Plaintiff's lawyers probably er on the side of taking bad malpractice cases. We all have had the experience of wondering a trial what we ever saw in the cas Some 65 to 80 percent of the malpractice cases are lost at tri according to various national studies. The time to gather the records, consult the expert and think hard about the coming months is obviously at the outs of the case. If the anticipated f is not going to cover the hours and the expenses you are advancing, it takes only a little cou age to turn down the case, no matter how egregious the wro seems to be.

One last word of caution on how to turn down cases. If the has been personal contact with the prospective client and esp cially if some investigation was done, the practice of "defensiv law" calls for a letter to the clie (some send it registered mail) which it is made clear that you are not going to handle the cas setting forth reasons. You shou not say that it is not a good cas you don't know that. State that you don't want to handle the case, but that you are not the la word. There may well be other lawyers who would start suit o these facts. And do your best t inform the person of the applicable statute of limitations.

If I had followed my own advi consistently over the years, I would be writing this from St. Moritz, but it so happens I am my office in New York, still tryi to profit from my prior mistakes.□

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References:
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2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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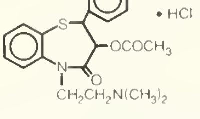

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Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash asthenia (1.2%), AV block (1.1%). In addition, the following were reported infrequently (less than 1%) with the order of p tion corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, b dia, palpitations, congestive heart syncope.
Nervous System:	Paresthesia, nervousness, somn tremor, insomnia, hallucinations, and a
Gastrointestinal:	Constipation, dyspepsia, diarrhea, v mild elevations of alkaline phosphatase SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photose
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing epis vasospastic angina developed periods of transient asymp asystole approximately five hours after receiving a single dose of CARDIZEM.

The following postmarketing events have been reporte quently in patients receiving CARDIZEM: erythema multifor kopenia; and extreme elevations of alkaline phosphatase SGPT, LDH, and CPK. However, a definitive cause and effect these events and CARDIZEM therapy is yet to be establish

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been Single oral doses of 300 mg of CARDIZEM have been well t by healthy volunteers. In the event of overdosage or exag response, appropriate supportive measures should be emp addition to gastric lavage. The following measures may be con

Bradycardia	Administer atropine (0.60 to 1.0 mg). is no response to vagal blockade, ad isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixe degree AV block should be treated w diac pacing.
Cardiac Failure	Administer inotropic agents (isopro dopamine, or dobutamine) and diuretic
Hypotension	Vasopressors (eg, dopamine or leva bitartrate).

Actual treatment and dosage should depend on the severi clinical situation and the judgment and experience of the physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 and from 560 to 810 mg/kg, respectively. The intravenous L these species were 60 and 38 mg/kg, respectively. The oral dogs is considered to be in excess of 50 mg/kg, while letha seen in monkeys at 360 mg/kg. The toxic dose in man is not but blood levels in excess of 800 ng/ml have not been ass with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic nary Artery Disease or Angina Pectoris at Rest Due t nary Artery Spasm. Dosage must be adjusted to each p needs. Starting with 30 mg four times daily, before meals bedtime, dosage should be increased gradually (given in doses three or four times daily) at one- to two-day interva optimum response is obtained. Although individual patie respond to any dosage level, the average optimum dosag appears to be 180 to 240 mg/day. There are no available data ing dosage requirements in patients with impaired renal or function. If the drug must be used in such patients, titration s carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abor anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may b coadministered with short- and long-acting nitrates, b have been no controlled studies to evaluate the ant effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 10 0088-1771-47) and in Unit Dose Identification Paks of 10 0088-1771-49). Each green tablet is engraved with MARION side and 1771 engraved on the other. CARDIZEM 60-mg tablets are supplied in bottles of 100 (NDC 0088-1772-47) an Dose Identification Paks of 100 (NDC 0088-1772-49). Eac tablet is engraved with MARION on one side and 1772 on t

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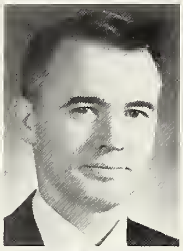
McLaughlin

hoda Powsner, MD, JD, Ann bor, was awarded "Professional oman of the Year" at the 1984 ichigan Association of the Pro- ssions award dinner. . . . **William wman, MD,** Flint, and **Thomas cConnon, MD,** won the Michi- n State University Research y competition for a paper co- blished titled, "Use of ul- sonography vs. clinical factors estimate date of confinement". . **Miriam S. Daly, MD,** Albion, s been appointed to the Ameri- n Hospital Association Council Hospital Medical Staffs for a ee year term starting in 1985. . **John Popovich, MD,** Franklin, s elected to Fellowship in the ,000 member national medical ecialty society. Popovich, a ecialist in pulmonary and criti- care medicine, will be honored the American College of Phy- ians' annual session in shington, DC . . . **Alfred wanson, MD,** Grand Rapids, s Honored Visiting Professor the 3rd American and Carib- an Orthopaedic Congress, and XVI Central American Con- ss of Orthopaedics and umatology held November th to 30th in Panama City, ama, where he presented an tructional course on surgery the hand. In addition, he was senter at the XX Anniversary eting of the French Society of nd Surgery held in Paris, nce. In October, Doctor Swan- received the National Volun- r Service Citation from the Na- al Arthritis Foundation for his years of dedicated work in re- rch and in the treatment of the arthritis. It was recently announced that Doctor Swanson will receive the University of Illinois Alumni Achievement Award for 1985. . . . Chairman of the Young Investigators' Awards Committee is **Bertam Pitt, MD,** Ann Arbor. . . . **Beatrice Madrazo, MD,** Detroit, recently was elected to the Board of Governors of the American Institute of Ultrasound in Medicine. She also is a member of the Education Committee and the International Relations Committee of the AIUM. . . . **Patti Peterson, MD,** a recent graduate of Wayne State University School of Medicine, won the Muscular Dystrophy Association fellowship as a result of a nationwide competition. . . . **Thomas Griffith, MD,** Marquette, recently was appointed assistant dean, Michigan State University, and vice president of the Upper Peninsula Health Education Corporation. . . . **Paul R. Lichter, MD,** Ann Arbor, was recently elected Secretary for Program of the American Academy of Opthalmology. . . . **Hari Malik, MD,** St. Joseph, was elected to the Board of Directors of the American Diabetes Association Michigan Affiliate last month. . . . **Daniel West, MD,** Escanaba, received the Upper Peninsula Senior Student Scholarship Award for personifying the goals and the objectives of the Escanaba Medical School training program and for expressing a strong committment to return to the UP to practice medicine. . . . **Frederick V. Minkow, MD,** Bloomfield Hills, will serve as the new president of the Oakland County Medical Society. Doctor Minkow is an orthopaedic surgeon specializing in hand surgery. The new president-elect of the county medical society is **John H. McLaughlin, MD,** Birmingham. **David R. Calver, MD,** West Bloomfield, will serve as secretary, and **Myron M. LaBan, MD,** Bloomfield Hills, will serve as treasurer of the 1,300 member county medical society. . . . The following doctors were among twenty-nine physicians honored for their 30 years of service with Cottage Hospital in Grosse Pointe: **James Danforth, MD; George Rogers, MD; Walter Bernard, MD; Merton Wilson, MD; Donald Sweeny, MD; C.J. France,**

Minkow

Powsner

Rogers

Swanson

Continued on page 120

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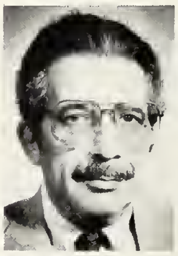
MD; Lyle Korum, MD; David Barker, MD; Richard Royer, MD; Milton Reuger, MD; Malcolm Kelson, MD; Marion Scott, MD; Aaron Farbman, MD; Harol Cross, MD; Wayne Jacobs, MD; Virgil Goodman, MD and Delmo Pans, MD. ... **Terry M. Silver, MD,** Ann Arbor, recently assumed the position of Associate Chairman within the Department of Radiology at the University of Michigan. ... **Harold Plotnick, MD,** Franklin, has been elected to a four-year term on the Board of Directors of the American Academy of Dermatology. ... **George F. Newman, MD,** Dearborn, will serve as president of the Michigan Psychiatric Society in 1985. ... **Fred C. Sabin, MD,** Marquette, received an honorar doctor of science degree from Northern Michigan University fo his outstanding service as an opthalmologist. ... **Billy B. Baumann, MD,** Pontiac, is vice-chairman for the second year o the Committee on Allied Health Education and Accreditation. Th AMA committee accredits approximately 3,000 allied health programs, hospitals and universities.

Cooper

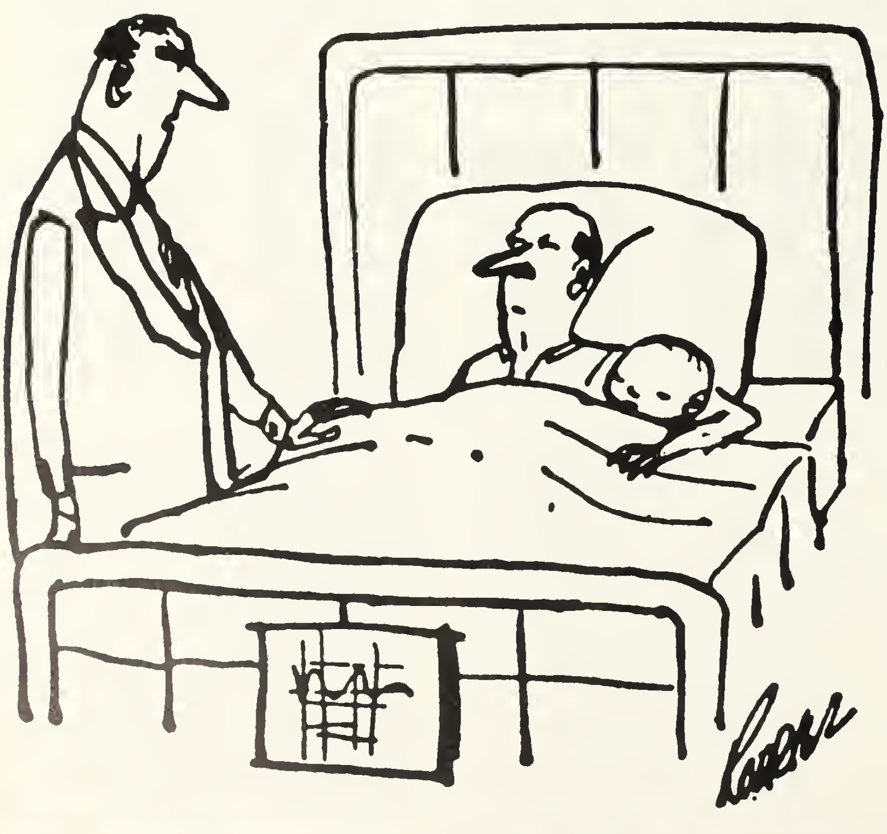
Farbman



Krome

Newman

... Upjohn Vice Chairman of the Board **Theodore Cooper, M PhD,** recently was one of three people to receive a Milto Helpern Library of Legal Medicine Memorial Award for 1984. His distinguished service award recognizes outstanding contributions to the field of healt care policy and medical care ad ministration. Other recipients were Jonas Salk, MD, ScD, LLD, PhD, and New York Mayor Edward Koch. ... Chairman of the scientific advisory board to the Michigan Chapter, National Foundation for Ileitis and Colitis is **Jason Bodzin, MD**,Southfield. The same organization honored **Bernard M. Schuman, MD**, Detroit for his past service in that position. ... New secretary of th Association of Philippine Practic-ing Physicians of America is **No berto Sugayan, MD**, Bloomfield Hills. **Vivina Rosa, MD**, is on th organization's board of governors. ... Michigan Association o the Professions board of director members include **Jack Barry, MD** Saginaw; **Richard Gascoigne, MD**, Adrian; **Ronald Krome, MD** Royal Oak and **Louis Zako, MD** MSMS president, Dearborn Heights. **Winifred Oyen, MD**, Freeland, was installed recently as the association's treasurer.☐



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Victor Azuela, MD
Battle Creek

Doctor Azuela died October 30, 1984 at the age of 69. He received his medical degree in obstetrics and gynecology in Mexico, then came to the U.S. in 1956 and established a psychiatric practice in Battle Creek. Doctor Azuela was an authority in alcoholism treatment and was affiliated with Wayne County General Hospital, Kalamazoo Hospital, and the former Sanitarium Hospital in Battle Creek.

Joseph M. Croman, MD
Mt. Clemens

Doctor Croman died at the age of 89 on October 14, 1984 after battling cancer for nine years. He attended Wayne State University School of Medicine. Doctor Croman was an Otolaryngologist and served on the staff at St. Joseph Hospital in Mt. Clemens.

Joseph D. Heaslip, MD
Hastings

Doctor Heaslip died February 14, 1984 at the age of 89. He attended Manitoba University Medical School in Manitoba, Canada, and was affiliated with Rennock Hospital in Barry County.

James R. Jeffrey, MD
Battle Creek

Doctor Jeffrey died June 28, 1984 at the age of 95. He was Medic Director of the former Battle Creek Sanitarium. He attended the University of Illinois School of Medicine and served as a U. Navy Medical Officer from 191 until 1922.

Thomas Lucas, MD
Lansing

Doctor Lucas died April 14, 198 at the age of 87. He attended the University of Toronto Scho of Medicine and was affiliated with Ingham Medical, E.W. Sparrow Hospital, and St. Lawrence Hospital in Lansing.

William W. Nicholls, MD
Flint

Doctor Nicholls died at the age of 63 on November 22, 1984. He attended the University of Michigan Medical School and was director of pediatrics at Mc Children's Health Center in Flin

George J. Smit, MD
Holland

Doctor Smit died November 2 1984 at the age of 58. He attended the Indiana University School of Medicine and was in the U.S. Navy from 1949 until 1952. Doctor Smit specialized internal medicine and was affiliated with Holland Hospital.

Ralph Wadley, MD
Scottsdale, AZ

Doctor Wadley, formerly of Eas Lansing, died October 19, 198 at the age of 83. He attended the Detroit College of Medicin and Surgery and specialized in surgery. Doctor Wadley was president of the Ingham Count Medical Society in 1950.

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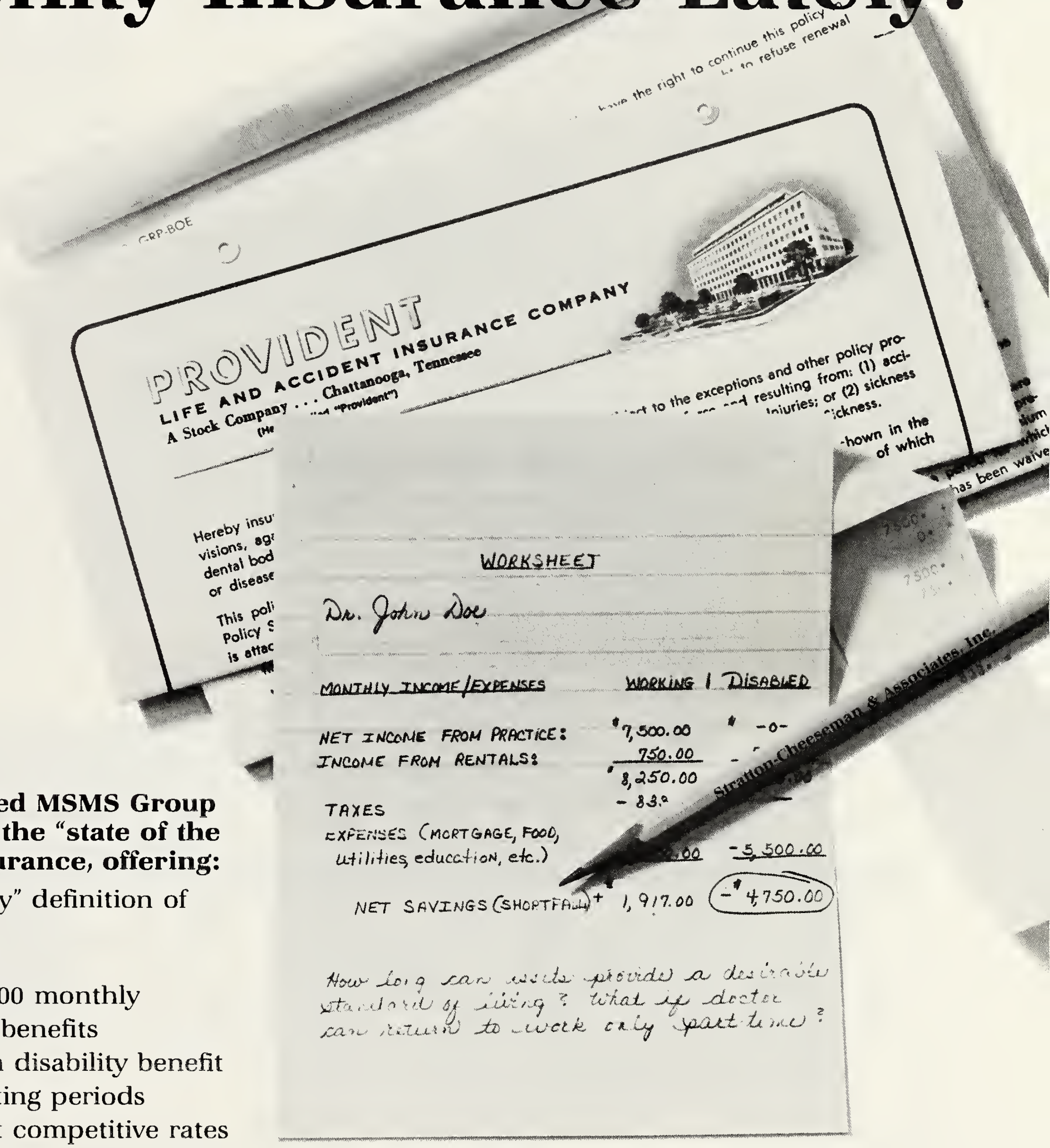

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Barry F. Bates, MD — R
600 S. Brown Box 905
Jackson 49204

Terrence P. Brennan, MD — IM/EM
11885 E. 12 Mile Rd.
Warren 48093

James P. Dempsey, MD — EM
62 Fairfield Dr.
Coldwater 49036

Michael J. Flohr, MD — OPH
1005 Green St.
Hastings 49058

John E. Garry, MD — CRS
72 Sheldon Ave., SE
Grand Rapids 49503

Russell LaBeau, Jr., MD — PD
560 Mitchell
Petoskey 49770

Mark P. Laughlin, MD — AN
1810 Wealthy St., SE
Grand Rapids 49506

David J. Lyman, MD — FP
3200 W. Liberty Rd. Box 1547
Ann Arbor 48106

William J. Malatinsky, MD — FP
312 S. Second
Alpena 49707

Thomas J. McKeon, MD — IM
601 Bridge St.
East Jordan 49727

Thomas K. Moore, MD — OPH
2909 E. Grand River #107
Lansing 48912

Jeffrey G. Obron, MD — OBG
6421 Maple Hills Dr.
Birmingham 48010

Ghanshyam N. Patel, MD — I
33163 23 Mile Rd.
New Baltimore 48047

Perry G. Pernicano, MD
4008 W. 13 Mile Rd. #40
Royal Oak 48072

Gary R. Peters, MD — IM
252 E. Lovell
Kalamazoo 49007

Madhusudhan Reddy, MD — I
1201 Stone St. #1
Port Huron 48060

Kathleen J. Sazama, MD — PT
One Atkinson Dr.
Ludington 49431

Samuel Scrinivasan, MD — P
830 S. Jefferson
Saginaw 48601

Michael VanderKolk, MD — G
999 Sixth St.
Traverse City 49684

SPORTS MEDICINE

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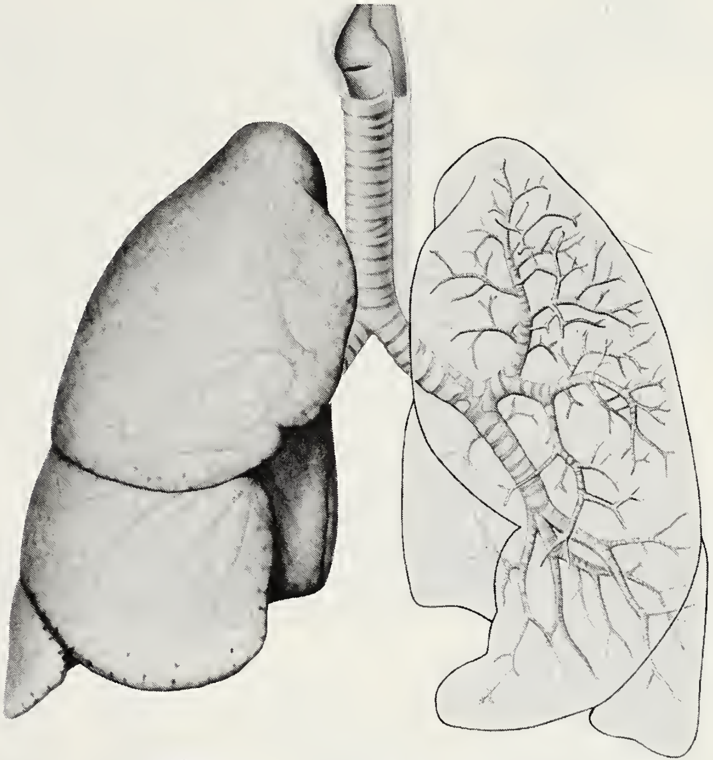
Consider the causative organisms…



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cefaclor
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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
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et Summary. Consult the package literature for prescribing ormation.

ications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the atment of the following infections when caused by susceptible ains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *eptococcus pneumoniae (Diplococcus pneumoniae), Haemoph- s influenzae*, and *S. pyogenes* (group A beta-hemolytic eptococci)

Appropriate culture and susceptibility studies should be formed to determine susceptibility of the causative organism Ceclor.

ntraindication: Ceclor is contraindicated in patients with known ergy to the cephalosporin group of antibiotics.

rnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALO- ORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. ERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL OSS-ALLERGENICITY OF THE PENICILLINS AND THE PHALOSPORINS, AND THERE ARE INSTANCES IN WHICH TIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously ny patient who has demonstrated some form of allergy, ticularly to drugs

Pseudomembranous colitis has been reported with virtually all ad-spectrum antibiotics (including macrolides, semisynthetic icillins, and cephalosporins); therefore, it is important to sider its diagnosis in patients who develop diarrhea in ociation with the use of antibiotics. Such colitis may range in erity from mild to life-threatening.

reatment with broad-spectrum antibiotics alters the normal a of the colon and may permit overgrowth of clostridia. Studies cate that a toxin produced by *Clostridium difficile* is one nary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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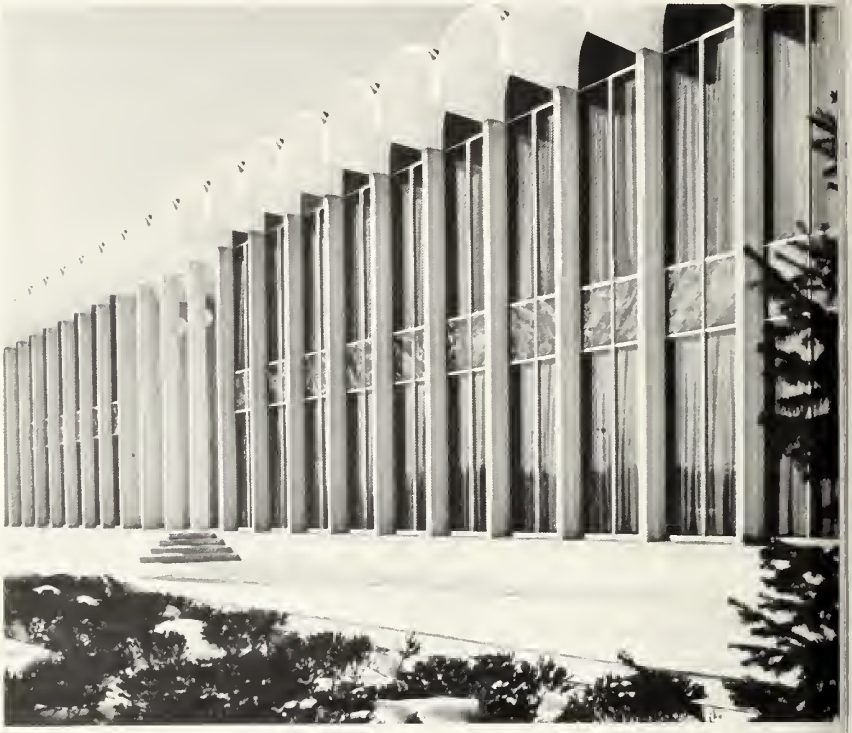
MEETINGS



MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

March 6, — MSMS Board of Directors, MSMS headquarters, contact: William Madigan, MSMS headquarters.

March 11, — MSMS Hospital Medical Staff Section, Michigan Inn, Southfield, contact: Thomas E. White, MSMS headquarters.

March 12, — MSMS/A Legislative Day, Civic Center, Lansing, contact: Viola M. Heins, MSMS headquarters.

March 20-21, — Michigan Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

April 26-28, — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

April 29, — MSMS/A Mini-Conference for County Officers, MSMS headquarters, East Lansing, contact: Viola Heins, MSMS headquarters.

May 6-8, — 59th Annual Sessio MSMS Auxiliary, Holiday Inn, Muskegon, contact: Viola M Heins, MSMS headquarters.

June 16-20, — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 18-21 — Midsummer Meeting, MSMS Board of Directors, Hidden Valley, Gaylord, contact: William Madigan, MSMS headquarters.

OTHER MEETINGS

May 15 — Michigan Allergy Society Executive Committee Meeting, University of Michigan, contact: David Seaman, MD, Secretary, Michigan Allergy Society, 8578 Canton Center Road, Canton 48187 (313) 453-2661.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313) 839-3011.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michiga law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicat a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: February 27, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved for:** 8 hours of Category I Credit.

Date: March 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Bronson Methodist Hospital, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: March 8-12, Opthalmology Basic and Clinical Review Course. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Kresge Eye Institute, Wayne State University School of Medicine. **Contact:** Division of CME, Wayne State University, School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201, (313) 577-1180. **Approved for:** 42 hours of Category I Credit.

Date: March 9, Type II Diabetes. Location: Michigan Osteopathic Medical Center. **Sponsor:** Michigan Osteopathic Medical Center. **Cost** $10.00 (There is no fee for Residents, Interns or Externs). **Contact:** Medical Administration, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr. Blvd., Detroit, MI 48208, (313) 361-8020. **Approved for:** 5.5 hours of Category I Credit.

Date: March 20-21, Michigan Conference on Maternal and Perinatal Health. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 13 hours of Category I Credit.

Date: March 22-23, Second Annual Chronic Pain Symposium. Location: Sheraton Fashion Square, Saginaw. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City, MI 48706, (517) 892-1501. **Approved for:** 13 hours of Category I Credit. //cmaDate: March 24, Urgent and Emergent Medicine. Location: Holiday Inn, Mt. Pleasant. **Sponsor:** Central Michigan Community Hospital. **Fo** General Practitioners. **Cost:** $48.00 f physicians, $15.00 for other profession staff. **Contact:** Frank D. Johnson, M (517) 772-4846. **Approved for:** 7 hou of Category I Credit.

Date: March 25-29, Family Practic 1985 - New Approaches to Commc Problems in Primary Care. Location: Tl Towsley Center, The University of Mich gan, Ann Arbor. **Sponsor:** Office of CN of the University of Michigan Medic School. **Contact:** Dove Margenau, The C fice of CME, The Towsley Center, Box 05 The University of Michigan Medic School, Ann Arbor 48109-0010, (31 763-1400. **Approved for:** 36 hours Category I Credit.

Date: March 28, Practical Approach the Diagnosis and Treatment of Dia etes Mellitus and Related Problems. L cation: Fetzer Center, Western Michig University, Kalamazoo. **Sponsor:** Sout western Michigan Area Health Educati Center and the Michigan Affiliate of t American Diabetes Association. **Co** $40.00. **Contact:** Charles L. Zeller, Jr., M Director of Continuing Medical Educati SMAHEC, Stryker Center, 4th Floor, 15 Gull Road, Kalamazoo, 49001. **Approv for:** 5 hours of Category I Credit.

Date: April 10, Primary Care Medicin An Exciting Frontier Revisited. Locatio Henry Ford Hospital. **Contact:** Henry Fo Hospital, Continuing Medical Educati 2799 W. Grand Blvd., Detroit 482 (313) 876- 3073. **Approved for:** 16 hou of Category I Credit.

Date: April 18, Pulmonary Rehabilitati Synopsis. Location: Sheraton In Kalamazoo. **Sponsor:** Borgess Medic Center and Southwestern Michigan Ar Health Education Center. **Cost:** Physicia $65.00, Others - $45.00. **Contact:** Ke Elder, Borgess Medical Center, 1521 G Road, Kalamazoo 49001. **Approved f** 5.5 hours of Category I Credit.

DATE: April 18-20, 14th Annual Way State University Critical Care Sy posium. Location: Northfield Hilton, Tr **Sponsors:** Wayne State University, D partment of Surgery, Michigan Comm tee on Trauma, and Michigan Society Critical Care Medicine. **Contact:** There Sokol, Wayne State University, Depa ment of Surgery, 6-C UHC, 4201 St. A toine, Detroit 48201 (313) 577-50

pproved for: 12 hours of Category I redit.

ate: April 24, Current Neurology - Clin al Neurology at the Bedside. Location: orgess Medical Center. **Sponsors:** orgess Medical Center & Southwestern lichigan Area Health Education Center. // ost: $85.00. **Contact:** William Daam, rgess Medical Center, 1521 Gull Road, alamazoo 49001. **Approved for:** 6 hours Category I Credit.

ate: April 24, Diabetes Management. ocation: Henry Ford Hospital, Detroit. **ontact:** Henry Ford Hospital, Continuing edical Education, 2799 W. Grand Blvd., etroit 48202, (313) 876-3073. **Ap oved for:** 6.5 hours of Category I Credit.

ate: April 25-27, ACLS - Advanced Car ac Life Support. Location: Genvieve U. Donald S. Gilmore Center for Health lucation, Kalamazoo. **Sponsors:** Bron n Hospital Life Support Office & South estern Michigan Area Health Education enter. **Cost:** $250.00. **Contact:** Cyndi ochevar Bouma, Bronson Methodist ospital, Life Support Office, 252 E. vell, Kalamazoo 49007, (616) 383-76. **Approved for:** 20 hours of Catego I Credit.

te: April 25-27, Hospice Dynamics d Realities. Location: Sheraton-South ld Hotel, Southfield. **Sponsor:** orgetown University, Hospice of utheastern Michigan and Michigan spice Organization. **Contact:** Commu Relations, Hospice of Southeastern chigan, 22401 Foster Winter Dr., South d 48075. **Approved for:** 6 hours of tegory I Credit.

te: April 26, Carcinoma of the Lung: Integrated Approach. Location: nry Ford Hospital. **Sponsor:** Henry d Hospital. **Cost:** $100.00 Practicing ysicians, $50.00 Residents & others. **ntact:** Henry Ford Hospital, Continuing dical Education, 2799 W. Grand Blvd., troit 48202, (313) 876-3073. **Ap oved for:** 7.25 hours of Category I edit.

te: May 2-3, American College of Sur ons. Location: Henry Ford Hospital, troit. **Sponsor:** Henry Ford Hospital. **ntact:** Henry Ford Hospital, Continuing dical Education, 2799 W. Grand Blvd., troit 48202, (313) 876-3073. **Ap oved for:** 13 hours of Category I Credit.

te: May 3, 19th Annual Cardiac Re bilitation & Exercise Testing Confer e. Location: Martin Verzi Auditorium - gess Medical Center, Kalamazoo. **onsor:** Southwestern Michigan Area alth Education Center and Institute for diovascular Health and Rehabilitation. **st:** Physicians, nurses, exercise person - $75.00, Students - $35.00. **Contact:** Morgan, Institute for Cardiovascular alth and Rehabilitation, Borgess Medi Center, 1521 Gull Road, Kalamazoo 001, (616) 383-8342. **Approved for:** hours of Category I Credit.

e: May 6-8, Hemodynamic Monitor VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical Center. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: May 8, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343- 3877. **Approved for:** 8 hours of Category I Credit.

Date: May 9-10, Aspiration Needle Biopsy. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 13 hours of Category I Credit.

Date: May 17-18, Neurological Update. Location: Henry Ford Hospital, Detroit. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 13 hours of Category I Credit.

Date: May 20, A Tangled Web: Consideration of Brain Death. Location: Henry Ford Hospital, Detroit. //Contact: Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: May 30-31, Surgical Endoscopy. Location: The Towsley Center. **Sponsor:** The University of Michigan, Office of Continuing Medical Education. **Cost:** $295.00 Physician fee, $195.00 for others. **Contact:** Dove Margenau, The Office of Continuing Medical Education, The Towsley Center, Box 057, The University of Michigan Medical School, Ann Arbor 48109-0010. **Approved for:** 13 hours of Category I Credit.

Date: June 14-15, Current Topics in Ophthalmology and Symposium on Glaucoma. Location: Henry Ford Hospital, Detroit. //Sponsor: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 13 hours of Category I Credit.

Date: June 20-22, 35th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Resort. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

Date: July 25-26, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684, (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295.00 **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. Sponsor: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 20 hours of Category I Credit.

Date: November 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. 18 Category I Credits applied for.

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

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ZAKO/Continued

There is another approach vhich may have merit. Those of ou who attended the MSMS ublic Affairs/Leadership Conference in Lansing last fall heard effrey O'Connell, a law professor t the University of Virginia and o-author of the Michigan no-ault auto insurance law. His program is designed to settle nedical injury incidents through revised insurance plan that to-ally bypasses the tort system. His rogram received favorable com-nent by the attendees and pre-ently is being studied by MSMS or possible implementation on pilot basis. In view of Professor O'Connell's and others' findings hat the injured patient receives nly 25 to 27 cents of the mal-ractice premium dollar, the rest going for administrative costs, attorneys' fees, court costs, etc., it behooves all of us to look for more equitable and efficient alternatives.

A challenge

I sincerely doubt that most physicians are like dinosaurs. It is my impression that most of us are flexible, adaptable, and realistic. There is no doubt in my mind that we can ameliorate our present intolerable situation through a combination of careful planning, unity, self-discipline, and flexibility. Our past failure is not necessarily indicative of future failure, but more a challenge to do better. In order to do so, we need ideas from each of you. Most importantly, we need a consensus, not a splintering. There is little doubt in my mind that we are up to the challenge.☐

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By Louis R. Zako, M

Malpractice revisited

We all know how terribly unjust the present malpractice situation is, we all know how it significantly increases the total cost of health, both directly through the billions spent by physicians throughout the US on malpractice insurance and indirectly through defensive medicine. We all know how a variety of "legislative reforms" in various states has either failed to pass the state legislatures or has been struck down by the state courts, and we have all known the relative public indifference to our and their plight in this matter.

I even find myself using the term "malpractice" to indicate a systemized rip-off of physicians rather than the commission of an act of medical negligence leading to patient injury. After all, how can anyone reasonably assume that between one-fourth and one-fifth of the physicians in the United States commit "malpractice" every single year?

A January 6 article in the *Detroit Free Press*, headlined "Insurance Cost May Jump for State's Doctors" informed us that MPMLC and PICOM were filing rate increase requests of between 20 and 45 percent with the Michigan Insurance Bureau. Further, the article informed those of us who were not insured by Medical Protective Company that its premiums were increased an average of 50 percent last year. The dilemma for you and for me, in the light of this startling but not totally unexpected news, is how to respond appropriately. Feeling sorry for ourselves and whining, both privately and in public, I suspect is analogous to what the dinosaurs did eons ago.

Louis R. Zako, MD
MSMS President

Unquestionably the cry for "legislative reform" will once again arise from some quarter. As we have sadly learned in the past, there is no reasonable prospect of "legislative reform" so long as the battle is a pitched battle between doctors and trial lawyers. In such a pitched battle we are hopelessly under-armed and under-equipped.

Two alternatives

There are two alternatives, it seems to me, to a series of crises followed by pitched battles which may have merit for medium and long-term improvement in the
malpractice arena. One alternative is to wage the war on seve
fronts with several allies. After
although it is we physicians wh
are immediately affected by th
malpractice problem, it is
the public which ultimately has
the most to lose. Unfortunately
the public does not introduce bi
into the legislature, hire lobbyis
or even send a barrage of lette
to legislators demanding resol
tion to the malpractice mess.

Nonetheless, various sectors
of our society do have significa
stakes in resolving this issue. Ce
tainly, the business community
has expressed a strong interes
in controlling overall health ca
costs and a somewhat lesser i
terest in maintaining the quali
of care. Labor unions in Michig
have a deep and abiding inter
in preserving and promoting jo
in Michigan, with health care
costs apparently being an
important consideration in pro
moting greater employment.
Clearly, major health insurers a
finding it more difficult to pass
on to their customers increase
health care costs through increased premiums. All of these
groups should be in the trench
with us and in forthcoming legislative battles. If they are not,
should not undertake additiona
suicidal missions. Melding a co
alition of these and other grou
is a major challenge for MSMS
one that we should immediate
undertake.

Doctor Zako, Dearborn Heights, is MSMS president.

Continued on page 1

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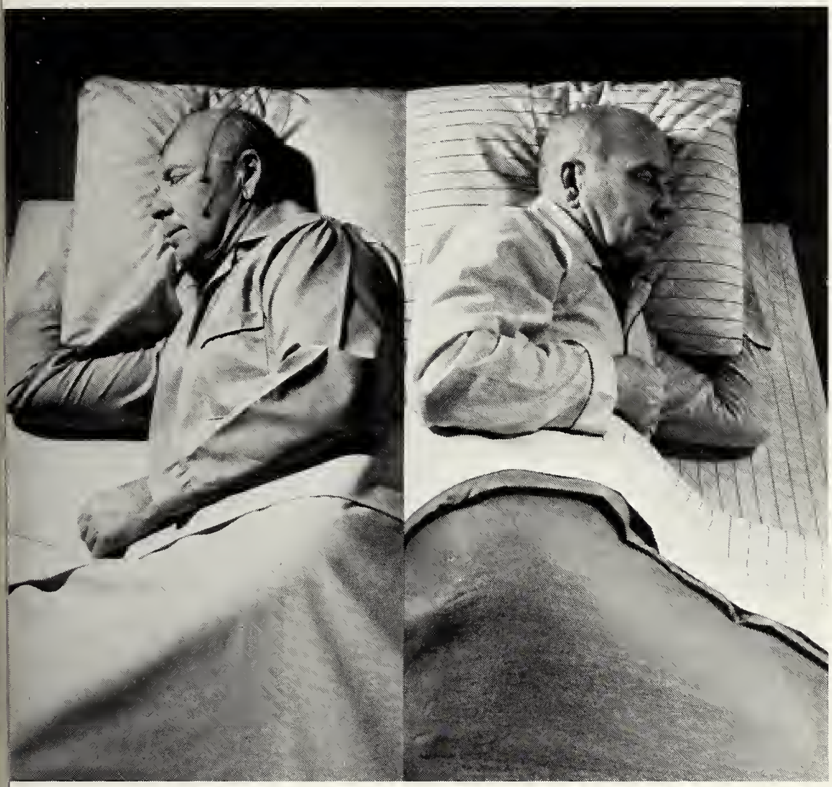

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MICHIGAN MEDICINE

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Caring for the elderly

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March 1985, Vol. 84, No. 3

MICHIGAN MEDICINE

MICHIGAN
MEDICINE
Caring for the elderly

bout the cover:
rs. Vera Wellman and Brian reenhoe are generations apart ıt enjoy good health *and* each her's company. Health care of ır aging population is the focus this month's Special Report.
hoto by Kim Kauffman

ı next month's issue of *Michi- an Medicine:*
he changes and controversies f imaging technology will be xplored.

Special report

138 By the year 2000, persons age 65 and older will represent more than 13 percent of the US population. The ramifications of this demographic change will be many and varied, and will certainly influence the delivery of health care. Some of the special considerations involved in the care of the older adult are addressed here, including the future for Medicare financing; the comprehensive approach to health care; prescribing for the elderly; abuse of adults; individual case management; incontinence and sensory impairment; Allen Dengiz, MD; Judy Marr; James G. O'Brien, MD; Janet D. Olszewski, MSW; Deborah Zannoth

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By Marguerite Shearer, MD

The special challenges of caring for the elderly

Dr. Shearer

Medical care of the aging is challenging, provocative, and rewarding. In my family practice it is my privilege to interact with patients of all ages — the current range is from newborns to 106!

Elderly patients have many of the same needs as younger people, but often present them differently. All are helped most readily by physicians who promote hope, courage, and trust. A frequent challenge is helping elderly patients understand their medications and the importance of taking them as prescribed. Written instructions can be very helpful for them to refer to later.

There are patients who expect that the solution to all problems will be found via prescriptions. William Osler, MD, stated, "The desire to take medicines is perhaps the greatest feature that distinguishes man from animals." Some patients feel the receipt of a prescription is necessary to acknowledge and verify their illness. In addition, the use of nonprescription drugs in self-medication can range from innocuous "home remedies" to potentially dangerous substances. Drug-disease contraindications and drug-drug interactions are common hazards to be avoided, particularly with aged patients.

Treating physicians must remember, too, that an environment of human warmth is very important to many older patients. For those who have lost their spouses, or are otherwise estranged, touching and holding needs often go unfilled.

Some studies have shown, though, that elderly patients who have pets do better than those who do not. One day while rounding at a nursing home, I saw a pet visitation. A veterinarian had brought beautifully groomed, healthy appearing cats and dogs to the facility. Patients were brought to an activity room and their wheelchairs formed a large circle. The cats were comfortably sprawled on patients' laps, and a golden retriever played in the center of the circle with a tennis ball. The dog placed the ball on an old man's lap: initially there was no response: then his hand brushed the ball to the floor. The retriever happily went after it, then gently placed it on another person's lap. This process was repeated again and again, much to the delight of the patients and the dog.

Simple, fostering efforts like this are central to the ongoing challenge in caring for our elderly patients: to enhance quality of life as we increase longevity. ☐

Doctor Shearer, Dexter, is a family physician and an MSMS district director.

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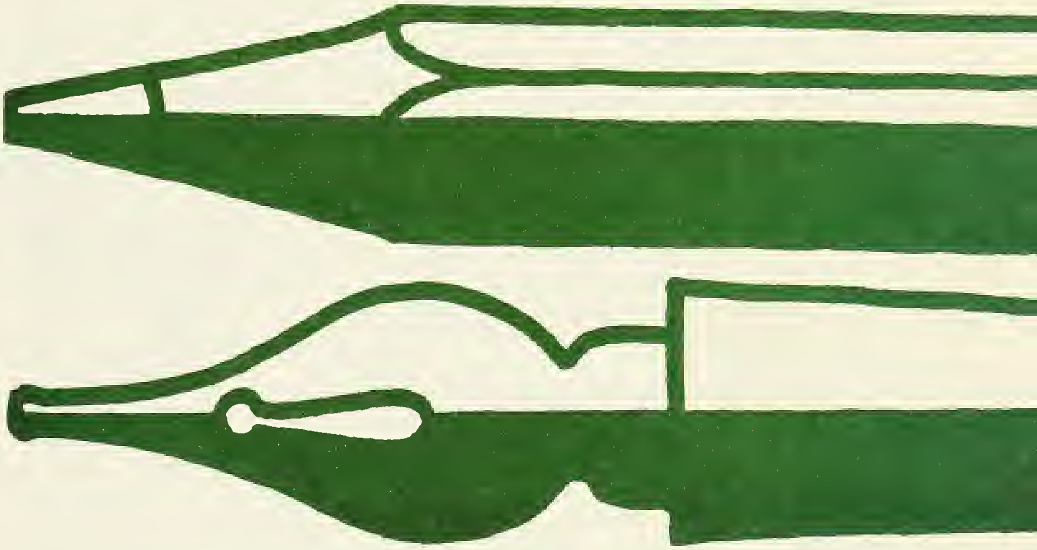

Vorld Medical Relief collecting lrugs for needy

Who bugs the MSMS more han I do?? But the needs of this vorld cause me sleepless nights, nd I feel morally bound to tap very resource possible to see hat WMR is receiving each and very medical crumb there is so hat we can pass them along to he sick poor here and abroad.

Please, please plug our needs very chance you get — at every neeting — so your physicians will now to save their good date rug samples for us; so your hysicians will know to ask at the ospitals they serve that they ave dressings, sutures, disposale items from opened sterile acks. All they have to do is the aving of these items. We will pick them up. All they have to do is call our office at (313) 866-5333 and a volunteer will come to their office or a hospital and get the items.

Last week a 48 foot trailer left our warehouse containing 33,999 pounds of medicine, I.V. solution, medical equipment and supplies for Guatemala and El Salvador. (We were told the doctors would accept outdated I.V. solutions!) The packing and distribution of this shipment was handled by the Air Commando Association (retired medics and doctors, not military) who have come out of retirement to help the refugees in these two desperate areas. Today we loaded a 40 foot container (the 25th) for Poland, where hospitals are washing their dressings and patients are asked to bring their own food, medicine and dressings. Conditions outside of this country are terrible, and the *need for drugs at an all time high.*

We continue with our free prescription program for the needy elderly in the tri-county area who qualify for our program by low income and banking. They are not welfare or Medicaid recipients, and all information is documented. The number of drugs we must purchase for this program is ever mounting as pharmaceutical houses (our largest source of medication) are not sampling as they used to. We would like to add to this program but cannot because we are too low on drugs.

Thank you for your support of our work, and we hope and pray the urgency of this request will become known to the members of the MSMS.

Mrs. L. G. Auberlin, President
World Medical Relief Inc.

By Judy Marr, Edito

Caring for our elder patients

By the year 2000, persons 65 years of age and older are expected to represent more than 13 percent of the U.S. population. This percentage may climb to more than 21 percent by 2030.

The importance of these statistics to the delivery of medical care is the reason for this special report. It also is the reason that MSMS now has an active Committee on Aging, which has advised on preparation of this special report.

Chronic illness increases dramatically with age. According to a brochure published by the American Association of Retired Persons, the 65+ group represented 11 percent of the population in 1980 but accounted for 31 percent of the total personal health care expenditures. Older persons averaged $2,640 spent per year for health care, more than three times the amount spent for their juniors.

All Americans have a major stake in our elder citizens' health care, as benefits from government programs cover about two-thirds of their health expenditures, as opposed to less than one-third of the care for persons under 65.

"Our MSMS committee feels it is important to widen the horizons of our colleagues in regard to education and service to the aging patient," said William T. Bateman, MD, Kalamazoo, chairman. "That is one of the reasons for our existence."

"We want to help the practicing physician to increase interest and improve attitudes toward care of the elderly."

Those sentiments are expressed in the committee's official purpose: "The committee examines the health status of senior citizens. Activities include advocating preventative medicine programs and providing physicians with an overview of the medical, social and psychological needs of the aged patient. The committee works with the Institution of Gerontology at the University of Michigan, and with the State Office of Services to the Aging."

Doctor Bateman himself devotes more than 50 percent of his practice to geriatric medicine He is medical director of the Upjohn Community Nursing Home in Kalamazoo.

"I have a very strong concern for the care of the aging both in my practice and in my personal life," he says.

He credits increasing public pressure and changing attitudes with turning physicians' focus toward the elderly. It has worked, he said, as evidenced by much-requested geriatrics medicine courses developed by the Committee on Aging and presented during the past three years at th MSMS Annual Scientific Meetings.

In addition to the Annual Scientific Meeting courses, the committee supports Senior Power Day, scheduled for May 15 this year, and Older American Month in May.

The committee also is plannin a fall MSMS Conference on Agin

d provides groups with lectur-
s on geriatric topics.
"We're pushing to make infor-
ation on our older citizens'
edical needs more available
ound the state," says Doctor
ateman.
The committee has a subcom-
ittee on nursing homes which
studying what's available and
hat's needed in nursing home
re, in order to determine how
hysicians can meet the needs.
Serving with Doctor Bateman
n the committee are Harvey M.
ndre, MD, Grand Rapids; Mrs.
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ichard H. Wakulat, MD, Petos-
ey; Phillip D. Wiley, U-M; Thomas
Northey and Janet Olszewski,
oth of Lansing.☐

Facts about our aging population

According to the American Association of Retired Persons:

- The 1980 census reported 25.5 million persons 65 years and older. This represents 11.3 percent of the American population, about one in every nine persons. The number of older Americans increased by 5.5 million or 28 percent since 1970.
- Of the 25.5. million persons 65+ in 1980, there were 15.2 million women and 10.3 million men, or 148 older women for every 100 older men. The ratio of women to men increases with age, ranging from 125 for the 65-69 group to a high of 229 women to 100 men for persons 85 and older.
- Since 1900, the percentage of Americans 65+ almost tripled (4.1 percent in 1900 to 11.3 percent in 1980), and the number increased more than eight times (from 3.1 million to 25.5 million).
- Of the over-65 population in 1980, 15.6 million were between 65-74 years, and 2.2 million were 85 years or older.
- In 1980, persons reaching age 65 had an average expectancy of an additional 16.4 years. Females at 65 could expect to live an additional 18.4 years, males could expect an additional 14.1 years.
- A child born in 1980 could expect to live 73.6 years, about 26 years longer than a child born in 1900. The major part of the increase occurred because of reduced death rates for children and young adults. More people now reach old age, but then do not live much longer than their ancestors.☐

By Deborah Zannot

Financing health care for seniors is government's ongoing challenge

Health care costs continue to rise and the government continues to seek solutions to the increasing Medicare budget. The recently introduced 1986 budget for Medicare requires reductions in expenditures that include an extension of the current physician fee freeze, a one-year freeze in hospital payments, and a 50 percent reduction in indirect graduate medical education payments to teaching hospitals.

It is also anticipated that the Department of Health and Human Services will deliver to Congress by July a report on physician reimbursement options. There is tremendous speculation that the report will outline a DRG payment option for physicians. Other reimbursement alternatives are: a relative value system which accounts for physician time, education, and skill level (currently being developed by the AMA); a voucher system wherein the Medicare beneficiary receives a given amount of dollars and then purchases his or her own health care services; or prepaid capitation, including a fixed amount per beneficiary to whomever assumes responsibility for financing.

Regardless of what happens in the immediate future, the issue of care for the elderly and methods for financing that care will be *the* issue for the 1990s.

The AMA at the Interim House of Delegates in December adopted guidelines to be considered in future public policy discussions regarding the Medicare program. Some of these guidelines are listed below:

- Access to quality health care for the elderly and the totally disabled through Medicare should be assured.
- The program should be on a fiscally sound basis to meet present and future needs in order to maintain access to quality car for Medicare beneficiaries.
- All beneficiaries under Medicare should have access to the same range of program benefits and should share in the program' cost in a way which encourages a cost-sharing limit to protect th patient from catastrophic medica expense.
- Medicare should provide payment for necessary medical services. It should be sufficiently flexible to make appropriate accommodations for new medical therapies and new technology. Expansion of benefits other tha for medical services should not divert Medicare resources.
- Medicare should assure freedom of choice of physician, provider, or system of health car delivery.
- Medicare should encourag delivery of services in cost-effective settings consistent with appropriate quality of care.

Ms. Zannoth is MSMS assistant for medical economics.

By James G. O'Brien, MD

Good geriatric care' requires a broad definition

Good geriatric care has many components, and certainly any physicians model all that onstitutes good geriatric care y offering continuity, accessa- lity and availability. But good eriatric care needs to have a roadened definition which in- udes some of the social, conomic, mental, physical, and elf-care aspects of elder health.

Two aspects in particular that eed to be emphasized include e function and the support sys- em, usually family, of an elderly erson.

amily considerations

A major part of taking care of lderly people, particularly those ho are more dependent, means aking care of, or at least relating , families.

Seventy percent of elderly per- ons receive help from the family, ut conversely, 50 percent of amilies receive help from the el- erly. Eighty percent of the sup- ort and assistance that the el- erly get comes from family embers. It follows, then, that e reason these people can be aintained in the community is amily support. If one in ten amilies could no longer sustain r maintain an elderly person we ould need to increase our nurs- g home beds by 20 percent.

unction in the elderly patient

Attaching a disease label to an lderly person, particularly a chronic disease that is irreversible, doesn't really tell us much about the health of that person. But describing how an individual functions quantifies the level of that disability.

Losses of function are quite common in the elderly. It is estimated that in terms of cognitive losses the prevalence of severe dementia at age 80 is about 20 percent. Likewise, reduction in physical mobility, which has a prevalence of 12 percent at age 65 to 69, rises to 80 percent at age 80.

This doesn't necessarily mean that everyone over the age of 80 is in "bad health", but by and large they have some limitation of function. In a North Carolina acute care hospital study of individuals over age 70, 65 percent had a problem with mobility, 21 percent were incontinent and 53 percent were incapable of self-care.

The World Health Organization recognizes the importance of function, and suggests that the health of the elderly is best measured in terms of function rather than in terms of pathology. A decline in function may be the first sign of disease in the elderly. For example, an elderly person may suddenly become incontinent as a result of pneumonia. Read more about incontinence on page 148 in this issue.

In terms of some reasonable goals in the care of aged patients, one should strive to maximize independence; maintain or restore function; and attempt, if it is the patient's desire, to maintain them in their home environment as long as possible.☐

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octor O'Brien is associate chairman nd professor, Department of Family ractice, Michigan State University ollege of Human Medicine.

Rx: Consider these findings when prescribing for older patients

he American Association of Retired Persons (AARP) has conducted a national survey of Americans over 45 years old to explore thoroughly these older consumers' practices and information levels when using prescription drugs. AARP was especially interested in the opinions and practices of older people, age 65 and above, and whether these were different than younger Americans, 45 to 64 years old.

Highlights of important findings from the survey are reprinted here:

- **Older Americans use more prescription drugs than others do.** Consumers over 45 years old are as likely as not to be taking a prescription drug. But older Americans (65 and older) are 2.5 times more likely (24 percent vs 9 percent) to be taking three or more prescription drugs on a regular basis than middle-age persons (45 to 54). A large majority of Americans (84 percent) over 45 take two or less prescription drugs at a time.
- **A significant number of consumers do not follow through on prescription drug programs.** Two out of five consumers have quit taking a prescription before all the medicine was used, and one out of five has not filled a prescription at one time or another. Consumers cite their concern for side effects, the belief that the drug would be, or was being, unhelpful, and an improvement in their condition, as the chief reasons for their non complying actions.
- **Side effects are experienced by two-fifths of the surveyed public, a large majority of whom are not forewarned.** Consumers report that large percentages of doctors and pharmacists never give them information on side effects. Older Americans feel they receive the least information of all people over 45 years old.
- **The public looks to doctors as their primary source of information on general health issues and prescription drugs.** They expect doctors to tell or give them all the information needed since a large number of consumers ask no, or only a few, questions. Very few consumers ask about non-drug alternatives.
- **Consumers say doctors do not provide adequate information on prescription drugs.** Many consumers say their doctors do not always give them thorough information about side effects, serious adverse reactions, alternative therapies, and other basic information. Older Americans receive less information from their doctors than do other consumers.
- **The surveyed public want printed leaflets of prescription drug information.** Doctors and pharmacists are the public's favorite sources of patient prescription information, but printed leaflets which can be read and reread are, for a strong majority of the public, the third preference as an information source.
- **Public knowledge about generics is fairly broad but often shallow.** Sixty percent of the public, and a smaller number, 53 percent of the elderly population, know about generics. A sizable portion of these consumers, however, do not have the correct facts on safety and effectiveness.
- **Consumers' use of generics is modest.** Only 42 percent of the surveyed public who know about generic drugs say they tr to buy and use them, but three-fourths of them admit to not asking their doctors to prescribe or their pharmacists to dispense generics. Consumers who buy generic drugs are usually better educated than those who do no use generics.

The following ideas can be helpful when prescribing medications for older patients:

- Have the patient bring in al medications he or she is currentl taking— including over-the-counter drugs.
- Prescribe low, well-spaced dosages at the start of a treatment regimen, and consider the impact of aging on drug metabolism and the possibility of multiple drug interactions.
- Tell the patient the name o the medication and what it is supposed to do; how and when to take the medication and what t do about missed or incorrect doses; when to have the drug refilled, if at all; what foods, drinks other drugs and activities the patient should avoid when taking the medication; and what side effects might result from taking th drug and what the patient shoul do if they occur.
- Supplement verbal counseling with written information to enhance prescription compliance Consider using materials such a the American Medical Association's Patient Medication Instructions (PMIs) or develop your ow instruction sheets. Some physicians supply a dosage calendar on which they write the dates an times the patient's medications should be taken.□

Vulnerable adults are at risk for abuse and neglect

The MSMS Committee on Aging and the MSMS Committee on Child Abuse and Neglect together produced the following information on the abused patient.

The greatest tragedy of abuse is that it violates the trust on which self-esteem and human relationships are based. The Michigan State Medical Society encourages physicians to be vigilant for the symptoms of abuse.

Because we cannot predict or prevent abuse, our only response is to protect those who are its victims. Physicians are aware of their responsibility regarding child abuse (Public Act 238 of 1975 as amended), but may not be aware of their responsibility under new legislation regarding vulnerable adults (Public Act 519 of 1982).

Who is at risk?

What groups are at high risk for abuse? Elderly persons living at home whose care needs exceed or will soon exceed the family's ability to meet them are especially at risk. Others include elderly persons whose primary caretakers are expressing frustration, and elderly persons whose primary caretakers are demonstrating signs of stress. Again, it is very important to involve the family in any interaction with an older adult who is somewhat dependant.

Also be alert toward elderly persons in families with a history of family violence or child or spouse abuse; elderly persons who abuse drugs or alcohol or who live with family members who abuse drugs or alcohol; those with past episodes of loss of control; and finally, elderly persons whose primary caretaker is under severe external stress, such as a loss of job, illness or other family problems.

Physicians should suspect abuse when they see frequent falls, substantial medication errors, or when the patient fails to thrive at home for no apparent physiological reason.

What is the doctor's responsiblity? A physician who, in his or her professional judgment, suspects that an adult has been abused, neglected, or exploited, or is endangered, shall make a report of the suspicion to the county Department of Social Services *if it is determined by the physician to be in the best interest of the adult.* The report shall not be considered a violation of any legally recognized privileged communication.

How is the doctor protected from liability? The identity of a person making a report shall be confidential, subject to disclosure only with the consent of that person or by judicial process. A person acting in good faith who makes a report or who assists shall be immune from civil liability which might otherwise be incurred by making the report or by assisting in the making of the report. The immunity from civil liability shall not extend to a negligent act which causes personal injury or death.

How to report

The report should be made to the county Department of Social Services, Division of Adult Protective Services or Child Protective Services. These agencies are listed differently in different phone books, but the following suggestions should help one to locate the correct number. Look in the white pages of the phone book under: Michigan State Government, Department of Social Services; emergency numbers on the first page of the phone book; the name of the county Department of Social Services.

If these suggestion fail, request help from the local police department. Another option is to call Michigan's Child Abuse Help Line. The Help Line is not for reporting abuse, but is a resource that can assist one to reach the county Department of Social Services and answer questions. Call 1-800-942-4357.☐

SPECIAL REPORT

By Janet D. Olszewski, MSW

Case management approach individualizes care for the aged

Managing an older patient with multiple pathologies is a delicate balancing act for the physician. It requires good information about the individual's physical, and social-emotional functioning, their family support system, finances and housing environment. Late reporting of illness symptoms and non-specific presentation of symptoms further complicates diagnosis and management of the patient. Furthermore, negotiaing a fragmented and complex array of home and community care services can make this all seem like an impossible task. DRGs have exacerbated the problem.

Recently, the Michigan Office of Services to the Aging (MOSA) embarked on a demonstration project utilizing a multi-disciplinary assessment and case management approach to assist individuals, their families and physicians to better manage their chronic impairments while maximizing independance and reducing the inappropriate use of institutions.

The Older American Act of 1965 and the Older Michiganians Act (P.A. 180 of 1981) establish the Office of Services to the Aging and Area Agencies on Aging as a visible network to "... foster the developments of a comprehensive and coordinated services system to service older individuals ...". At the level of state government the Office of Services to the Aging serves as an advocate for the needs of the elderly and works with other state agencies, departments and the legislature to better address this group's needs. Michigan is divided into fourteen planning and service areas with an Area Agency on Aging designated in each. It is the Area Agency's responsiblity to develop a coordinated service system for older adults within its geographic region.

Traditionally, the methods to accomplish this have been limited to the development of a plan for services based on a regional needs assessment: the solicitation, negotiation and funding of service contracts with community agencies and the funding for and provision of gerontological training for community based service agencies.

Area agencies traditionally are not service-providing agencies themselves. Over the last ten years funding has focused on assisting older persons to gain access to the service system (i.e. information and referral, outreach and transportaion services) and on the provision of home care (home health aide, personal care, homemaker, chore and home repair services). It is MOSA's intent to fill gaps in the existing service system and not to duplicate it.

Case management concept

Experience has taught us that, in spite of everyone's best efforts, some older adults fall through the cracks of the health care and social services system and do not receive the help which best addresses their needs. This has led MOSA to develop and test a case management concept for these "high risk" elderly in an attempt to reduce their use of institutions and better coordinate assistance for them.

Case management is not a new concept: social services literature has discussed it for nearly 40 years. Probably its widest application has been in the mental health system. Its application to the elderly population is less than ten years old and remains evolutionary. A federally funded research effort to study the provision of case management to an elderly population is in its final year with research results scheduled to be available in 1986. Several states now have developed case management systems, yet their impact on costs are still undetermined.

Because of strong belief that case management works best when aimed at elderly with multiple and complex needs, putting them at high risk of institutionalization, Michigan embarked on a project to test this idea and develop successful models.

The group targeted to receive case management are elderly persons with a combination of physical, social and emotional needs. The belief was once widely held that older people entered nursing homes because of functional limitations, but it is now known that the availability of family caregivers is more directly related to institutionalization. Hence, MOSA seeks to reach persons with multiple physicial problems and with a fragile or non-existant support system. These are the people most likely to benefit from the intensive intervention that case management provides.

Case management consists of five functions: pre-screening; comprehensive assessment; care plan development; service brokerage; and monitoring and reassessment.

Prescreening assures that help will reach those persons who can benefit most. Other persons can be served effectively by the existing service system and are referred appropriately. The comprehensive assessment con-

Continued on page 148

Ms. Olszewski is currently acting supervisor of the Health and Social Services Unit within the Michigan Offices of Services to the Aging.

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ducted by a nurse-social work team gathers data on medical diagnosis, drug regimens, physical, social and emotional functioning, finances and housing. This data is then translated, in consultation with the individual, their family and physician into a care plan which focuses on maximizing independance and bolstering family resources. Care plans typically include services from a number of community agencies, family members, other support systems and environmental modifications to the home.

The key advantage of this system for the client is the program's flexibility. It is not limited by regulatory constraints, and therefore is truly client-focused.

To date MOSA has funded two projects in the state. One serves Berrien, Cass and Van Buren counties and the other serves sixteen downriver communities in Wayne County.

Positive results

The first set of research results are in from the project serving the southwest corner of the State. Findings for the second program, the Information Center Wyandotte, will be available later this year. The findings so far demonstrate clearly that case management has a significant impact on health care utilization.

In addition, results showed that case management clients utilized health services with less frequency during the study year than did the control group who received services normally provided in the community. Case management clients had 25 percent fewer inpatient hospital commissions. They also used 13 percent fewer emergency room visits and 12 percent fewer nursing home stays. These findings represent a potential cost savings. Further, 60 percent of nursing home residents receiving case management during the study returned home with supportive services. This is certainly a positive outcome and another potential cost savings factor.

In more human terms, one family's feedback on the project sums it up: "The staff made it possible for the family to spend more of their time caring for the patient instead of arranging for and monitoring home care services."

At this time, the Office of Services to the Aging is ready to extend its effort into four additiona areas of the state. All projects wil incorporate physician referrals, physician involvement in care planning and professional review The expanded effort will provide further insight into the ability of professionals from a variety of disciplines to provide effective care to older adults with multipl and complex needs.☐

By James G. O'Brien, MD

Incontinence in the aged patient

Five to ten percent of the elderly in the community have significant incontinence, the involuntary loss of urine creating a hygenic or social problem. The prevalence of the condition rises dramatically with hospitalization: almost a third of all geriatric admissions are incontinent. Neurologic disease and being female increase the likelihood that a patient will be incontinent.

Aging doesn't cause incontinence, but contributes to it in a variety of ways including decreased muscle tone, mobility and bladder volume, and increased neurologic disorders. Uninhibited bladder contractions and nocturia increase with advancing age, as well.

Thirty thousand deaths in hospitals each year in the US are attributed to sepsis secondary to catheter placement with the economic burden estimated at about a billion dollars per year. An individual with incontinence requires two to three times the nursing care as other patients.

Five categories

Incontinence can be classified in five categories: 1) detrusor instability, 2) overflow incontinence, 3) sphincter insufficiency, 4) functional incontinence, and 5) iatrogenic incontinence. Detrusor instability occurs when uninhibited bladder contractions overcome sphincter resistance. Detrusor instability is known by a variety of other names including urge incontinence, unstable bladder, spastic bladder, uninhibited neurogenic bladder, and hyperreflexic bladder. In elderly people it is though to account for 50 to 70 percent of incontinence. It may occur alone or in combination with another type of incontinence. Causes include stroke and dementia, where voluntary ability to shut down the detruso nucleus is lost; and increased afferent stimulation from the bladder, as with cystitis or an impaction.

The latter reason is a deconditioned reflex. An elderly person who has an accident may cope by voiding frequently, which results in a smaller bladder, increased detrusor tone and more incontinence. The clinical features include urgency, frequency and nocturia, and these individuals tend to void small amounts.

Overflow incontinence, also known as paradoxical incontinence, is a difficult problem to manage. The bladder can only eliminate urine when it is distended to a great degree. Causes are outlet obstruction, commonl seen in males with prostatic disease or scarring, and the inabilit of the detrusor muscle to con-

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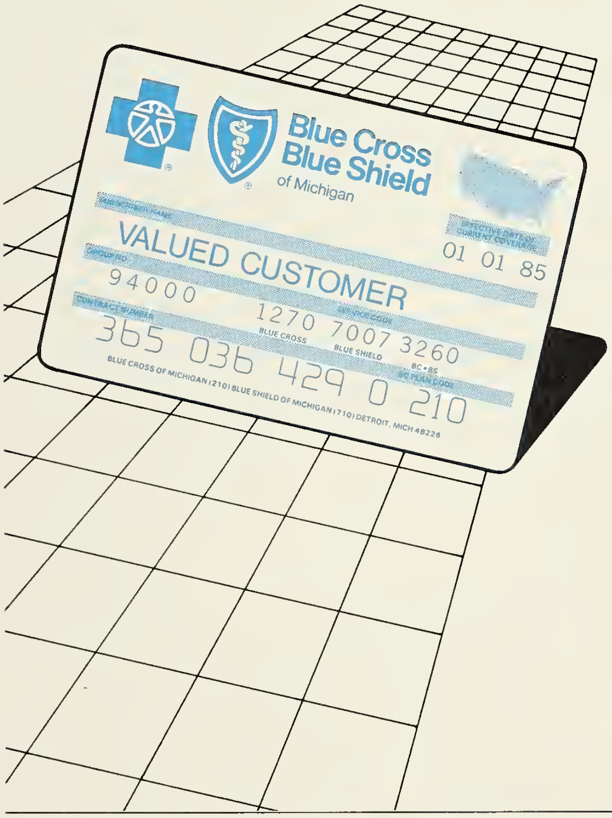
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tract because of nerve damage.

Many of these individuals do not experience a desire to void and typically have a low flow, dribbling, difficulty initiating urination and a large residual volume.

Sphincter insufficiency or stress incontinence is common in elderly women and can result from damage to the urethrovesical angle from previous pregnancy or surgery. Sometimes a lack of estrogen effect on the internal sphincter diminishes its ability to contract. Approximately 25 percent of these people also have detrusor instability.

With functional incontinance the collecting system functions well but the individual is unable to make it to the bathroom because of psychological reasons or mobility problems.

Iatrogenic incontinence may result from use of diuretics, especially the short-acting, potent type, as well as from sedatives, tranquilizers, restraints, muscle relaxants and sympathetic blockers.

Individual approach

Each patient needs to be evaluated in the context of his or her own environment. The evaluation will be different for the 75-year-old demented patient in a nursing home, than for an ambulatory, alert 80-year-old living independently.

In taking a history of an incontinent patient, a physician should determine presence of diseases such as diabetes mellitus, and ascertain duration, amount, frequency, presence of urgency, and whether urine loss occurs with a cough. Medication intake and output may also provide useful clues to determining the etiology, and use of an incontinence sheet can demonstrate a pattern of loss. Information about living situation, mental status, mobility level and manual dexterity also are helpful.

The physical examination should devote special attention to the neurological and genitourinary systems. Stroke, spinal lesions and peripheral nerve lesions secondary to trauma degenerative disease should be sought. Examination of anal wink, abdominal and cremasteric reflexes is imperative, and a pelvic exam can reveal atrophic vaginitis, loss of urethrovesical angle and stress incontinence. A rectal exam can reveal prostatic enlargement, impaction and anal sphincter tone. Bladder size can be estimated by palpation or percussion. In addition, manual dexterity in removing clothes should be checked.

Investigations should include the following: urinalysis—microscopic and if indicated, culture; SMAC, to check for metabolic abnormalities; thyroid function and VDRL; residual urine determination by catheterization after voiding. Residual urine tends to increase in elderly individuals up to 80 cc.

Special investigations sometimes needed include systometry, EMGs and urethral pressure determinations. The normal ranges for many of these investigations in the elderly are not well defined.

Management of incontinence

Determine mental status so that a specific plan can be implemented. Do establish a voiding schedule after studying the incontinence pattern and suggest voiding on a regular basis of 2-3 hours. Modest fluid control may be warranted but patient preference should influence any treatment plan. Minimize medications as side effects are frequent.

For detrusor instability, bladde retraining with repetitive contracting of pelvic muscles to dela urination may be effective. Medications that may prove useful include anticholinengics such as oxybutynin (Ditropan) or imipramine (Tofranil) in low dosage. Follow-up is important.

If the cause of overflow incontinence is obstruction, as in prostatic hypertrophy, surgery is the solution. If the etiology is neurological with adynamic bladder the management options include intermittent catheterizatio or the Crede maneuver. The latte option can be an excellent management method for individuals who have the motor and mental skills to accomplish it.

Pelvic floor exercises may be helpful for sphincter insufficiency but repetitive exercises may be difficult and demanding for an elderly person. With atrophic vaginitis the use of estrogen, either topically or orally, may prove useful. Phenylpropanolamine may be useful in those that can tolerate it.

With iatrogenic incontinence, removal of the precipitant, whether a diuretic, sedative, tranquilizer or beta blocker is in order.

When incontinence is intractable many options are still available including clamps, condom catheters, diapers, sheets and, finally, as a last resort, an indwelling catheter.

Immobility and incontinence are problems that can be managed in elderly individuals so tha comfort, dignity and maximal function and independence can be maintained.☐

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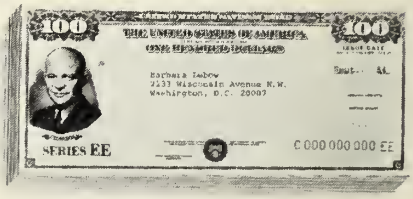

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By Allen Dengiz, MD

Tips on talking to older patients

These remarks are taken from Doctor Dengiz' presentation during a course at the 1984 MSMS Annual Scientific Meeting titled "Elder Care Management."

At around 30 we begin to age, and as the quote goes "we don't stop until we die". Physicians treating the older patient must be aware of the physiology of aging.

Sensory impairments, particulary hearing loss, are often the most apparent changes. The most common hearing problem in older adults involves the inability to distinguish among sounds, especially sounds like "th" and "sh" or "kkk". This hearing problem is present in about 30 percent of patients 80 years or older. They may hear what is said as words, but can't put sentences together or understand what is being said to them.

The older adult may not clearly hear what is being said and may nod his or her head inappropriately. This may be because they are tired of asking people to repeat the question, so they nod or shake their head, but they really are not hearing. So one must be very careful to speak slowly and in a low tone, as it is the higher pitch sounds that are difficult for them to pick up.

When interviewing an older adult, have a family member in the room so that they may add to the history taking process as well.

One other important thing to keep in mind when treating the elderly is that between 50 and 70 percent of what you tell your patients is forgotten when they leave your office. This holds true for patients of all ages, not just older people. One solution to this problem is to write things down, or have a family member accompany them to your office so that two people hear the instructions.

Mental health considerations

Twenty-five percent of the elderly have significant mental health problems, yet they rarely seek psychiatric services. Depression is often under the surface and physicians really don't focus on it. Older adults don't want to talk about mental health issues because they find them embarassing: physical problems are all right, but mental health problems are not. So, often times feelings are ignored.

It is important to note that the highest rate of successful suicide occurs in elderly males over the age of 85. An older adult who is talking about depression or taking his life must be taken very seriously. ☐

Doctor Dengiz is a clinical geriatrician at the Catherine McAuley Health Center and formerly with the U-M Turner Institute of Gerontology.

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By Monte D. Jahnke, JD

Prudent Purchaser Act summarized

The Prudent Purchaser Act was passed by the Michigan legislature in December. The MSMS Board of Directors closely monitored the development of the bill. Mitchell Rinek, MD, Lansing, chaired the MSMS Committee on State Legislation and Regulation's Subcommittee on Health Care Cost Containment, and testified before the legislature many times regarding the bill.

MSMS legal counsel has summarized the Act and its accompanying legislation as follows:

1) House Bill 5069 is the main piece of legislation known as the "Prudent Purchaser Act". It allows certain "organizations" as defined in the bill to enter into prudent purchaser arrangements. All other bills in the package constitute amendments to existing enabling acts. These amendments would allow the designated organizations to participate in PPA arrangements, to wit:

- Senate substitute for House Bill 4798: disability insurers, group
- disability insurers, and commercial health insurers
- Senate substitute for House Bill 4799 amendment to 1980 "Blues Act"
- Senate substitute for House Bill 4800 amendment to 1939 Blue Shield Act
- Senate substitute for House Bill 4801 amendment to 1939 Blue Cross Act
- House Bill 5067 amendment to HMO Act
- House Bill 5068 "Delta Dental Act"

2) Importantly, the amendments to Blues legislation (4799, 4800, and 4801) all allow for converting the Blues to a mutual format within certain statutorily set deadlines, in addition to allowing them to participate in PPA arrangements.

3) House Bill 5069 regulates only prudent purchaser arrangements originated by the organization designated in the accompanying bills. Importantly, Section 5 of 5069 purports an exemption for "health care providers". The bill defines them as health facilities or persons licensed under the Public Health Code, i.e. physicians, hospitals, nurses and other health care practitioners.

4) Organizations hoping to enter into PPA arrangements have discretion over the number of agreements entered into provided sufficient levels of care can be delivered. The levels are to be determined by the organization.

5) A formative organization must notify health care providers in a geographic area to be served by it of an opportunity to apply for membership. Written standards must be published and filed with the Commissioner of Insurance, and made available to all potential applicants.

6) Formative organizations must provide for professional review of care quality, personnel performance and utilization.

7) Separately licensed but competing health care providers eligible to deliver the same type of health care service must be offered an opportunity to apply fo participation in the provider pane being formed.

8) Providers may be removed for failure to comply with requirements in contracts.

9) Annual statements must be filed by such organizations reporting on their service performance and population served. Information filed must be maintained confidentially by the Commissioner of Insurance.

10) Any organization forming a prudent purchaser arrangemen is otherwise subject to its own enabling act and must maintain the PPA operation as a separate line of business.

11) There is a five year sunset provision on House Bill 5069 anc its related bills.

12) The related enabling acts provide for the offering of exclusive purchaser arrangements (EPAs) whereby the purchaser o service must only go to a limitec panel. If an exclusive arrangemen is offered, an option must be offered along with it allowing for patient financial incentives to go to the panel, but absent exclusivity. Non-participating providers who service persons who ar signed up with a PPA are guaran teed no less than 80% of the amount payable for the same service if it were rendered by a provider who was subject to a PPA agreement.

These bills should have little direct regulatory effect on provide based PPOs but because they wil be likely obtaining patients from organizations subject to the act, there will be a degree of indirec regulation.☐

Mr. Jahnke is an attorney with Kerr, Russell and Weber, MSMS legal counsel.

EXCLUSIVE

MICHIGAN GAZETTE

TALWIN® Nx...BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

T-540
NDC 0024-1951-04
100 tablets
IV
Talwin® Nx
Each tablet contains pentazocine hydrochloride, USP, equivalent to 50 mg base and naloxone hydrochloride, USP, 0.5 mg.
Caution: Federal law prohibits dispensing without prescription.
Winthrop

Talwin® Nx

Ⓒ IV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

Winthrop-Breon

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Please see following page for Brief Summary.

Talwin® Nx ⓘⓥ

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0 5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

TALWIN® Nx is intended for oral use only Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances (See **Drug Abuse and Dependence** section)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention, these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis

Precautions: *CNS Effect* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment In long-term use, precautions should be taken to avoid increases in dose by the patient *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting *Drug Interactions Usage with Alcohol* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed *Pregnancy Category C* Should be given to pregnant women only if clearly needed *Labor and Delivery* Use with caution in women delivering premature infants Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown *Nursing Mothers* Caution should be exercised when administered to a nursing woman *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope *Respiratory* Rarely, respiratory depression *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora *Ophthalmic* Visual blurring and focusing difficulty *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia *Other* Headache, chills, insomnia, weakness, urinary retention

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance

Dependence and withdrawal symptoms have been reported with orally administered pentazocine Patients with a history of drug dependence should be under close supervision Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx

The amount of naloxone present (0 5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine, however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated Assisted or controlled ventilation should also be considered For respiratory depression, parenteral naloxone is a specific and effective antagonist

Please consult full product information before prescribing

Winthrop-Breon
WIN 4-41415BR

Winthrop-Breon Laboratories
Division of Sterling Drug Inc
New York, NY 10016

MSMS legal counsel marks anniversary

During Ulysses S. Grant's second term, a Detroiter, James Keena, started his practice of law. One hundred and ten years later a firm that traces its beginnings to James Keena is still practicing law in Detroit. That firm is Kerr, Russell & Weber, MSMS legal counsel.

Kerr, Russell and Weber engages in a diversified practice, divided between corporate and litigation disciplines, including antitrust, general corporate, estate planning, the defense of medical malpractice litigation, products liability, taxation, health care and pension and profit-sharing matters. Among the firm's clients in health care work are Michigan State Medical Society, Michigan Dental Association and staffs of various hospitals throughout southeastern Michigan.

The firm is today led by A. Stewart Kerr, Robert G. Russell, Richard D. Weber, Donald C. Morgan, Kenneth J. LaMotte, Robert E. Gesell, Roy H. Christiansen, William A. Sankbeil, Robert R. Nix, II, C. Kenneth Perry, Jr., Monte D. Jahnke, Patrick McLain, Michael B. Lewis, and A. Nels Carlson.☐

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MEMBERS IN THE NEWS

App

Artinian

Dugan

Kammeraad

Lentini

Lugg

Martel

Neuman

Papp

Stawski

A. Swanson

Vanderkolk

Miriam S. Daly, MD, Albion, was recently appointed to the American Hospital Association Council on Hospital Medical Staffs. Doctor Daly is one of 15 physicians in the nation selected to serve a three year term ... **Dennis P. Swanson, MD**, head of Henry Ford Hospital's Division of Radiology Pharmacy Services, is the new chairman-elect of the Section on Nuclear Pharmacy of the American Pharmaceutical Association ... **Robert M. Lugg, MD**, Port Huron, is closing his practice as a pediatrician to head a research project for the US Army in Germany. Doctor Lugg will be involved in a program designed to assess the needs of developmentally handicapped children of US military personnel in Europe ... **Mark Novitch, MD**, Kalamazoo, was named vice president of the Upjohn Company. Doctor Novitch was formerly Deputy Commissioner of the US Food and Drug Administration ... The American College of Gastroenterology recently presented **John P. Papp, MD**, Grand Rapids gastroenterologist with the Samuel Wiess Award. The award recognizes outstanding contributions on behalf of the medical specialty and its practitioners ... **Joseph E. Johnson, III, MD**, well-known academic physician and medical administrator, was named dean of the University of Michigan's Medical School. Doctor Johnson was professor and chairman of the department of medicine at the Bowman Gray School of Medicine, Wake Forest University ... The University of Michigan Regents approved the establishment of the Fred Jenner Hodges, MD Professorship in Radiology and named **William Martel, MD**, Ann Arbor, as its first recipient. Doctor Martel is a professor and chairman of the Department of Radiology at U-M ... **Joseph R. Lentini, MD**, Grand Rapids, was awarded the MAP Outstanding Service Award in November ... **Peter B. App, MD**, Grand Rapids, was the host for the symposium on Infectious Diseases for Diagnosis and Treatment in the Office Practice of Family Physicians in October in Grand Rapids ... **Lloyd A. Kammeraad, MD**, Grand Rapids, has been elected chairman of the American College of Obstetricians and Gynecologists Michigan Section for a three yea term ... **C. Gary Artinian, MD**, Pontiac, recently was sworn in a a new member of the Wayne State University Board of Governors ... **The late Bertha Van Hoosen, MD**, was inducted recently into the Michigan Women's Hall of Fame. Doctor Van Hoosen established a national reputation for her procedures and techniques in appendi and hemorrhoid operations. She practiced medicine and surgery from 1863-1952 ... Michigan Chapter of the American College of Emergency Physicians presented **Harvey J. DeMaagd, MD** with the Meritorious Service Award. This award recognizes doctors for their pursuit of excellence in the principles and practice of emergency medicine ... **Willard S. Stawski, MD**, was installed as president of the Ken County Medical Society. Doctor Stawski is a general surgeon in Grand Rapids ... **Albert R. Dugan, MD** was elected president-elect and will take office in January, 1986. The county societ also elected **Kenneth J. Vander-Kolk, MD** to the Board of Trustees of the Kent Medical Foundation which gives financial assistance to area students pursuing careers in medicine ... **Alfre B. Swanson, MD**, Grand Rapids, recently lectured on implant arthroplasty of the hand and wrist at the International Symposium of Hand Surgery held in Vail, Col orado. Doctor Swanson also chaired the Specialist Session o Hand Surgery at the 16th Congress of the International Societ of Orthopaedics and Traumatology in London, England. He wa

Continued on page 16

PERSPECTIVES IN CANCER MANAGEMENT

Eight distinguished authorities present a variety of topics relating to cancer management in a one-day symposium.

Topics include:

- **Some Interesting Aspects of Pulmonary Collapse**
  Benjamin Felson, MD, professor emeritus of radiology, Department of Radiology - University Hospital; Cincinnati, Ohio
- **Conservative Surgery and Radiotherapy as an Alternative to Mastectomy for Early Breast Cancer**
  Jay R. Harris, MD, acting and clinical director - Joint Center for Radiation Therapy; Boston, Massachusetts
- **Endocrine Paraneoplastic Syndromes**
  William D. O'Dell, MD, PhD, chairman, Department of Internal Medicine; professor of medicine and physiology, School of Medicine - University of Utah; Salt Lake City, Utah
- **Radioiabelled Antibody in Cancer Therapy**
  Stanley Order, MD, director of radiology and oncology - Johns Hopkins Hospital; Baltimore, Maryland
- **Diagnostic and Therapeutic Strategies Based on the Biology of Bladder Carcinoma**
  George R. Prout, Jr., MD, F.A.C.S., chief, Urological Service - Massachusetts General Hospital; Boston, Massachusetts
- **Reflections on the Curative Treatment of Cancer of the Breast**
  Juan A. del Regato, MD, veterans administration distinguished physician, Department of Radiology - James A. Haley V.A. Hospital; Tampa, Florida
- **Modern Day Management of Ovarian Carcinoma**
  Robert C. Young, MD, chief, Medicine Branch - National Cancer Institute/National Institutes of Health; Bethesda, Maryland
- **Pain Management in Advanced Cancer**
  Michael H. Levy, MD, director of palliative care service - Fox Chase Cancer Center; Philadelphia, Pennsylvania

when Saturday, April 20, 1985
8:00 a.m. to 4:15 p.m.

where South Macomb Hospital -
Warren, Michigan

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advance registration	
physicians	$75
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allied health professionals	$25
registration at the door	**$80**

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For Advance Registration: send check payable to Detroit-Macomb Hospital Corporation Annual Seminar Fund to:

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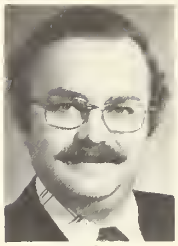
Hershey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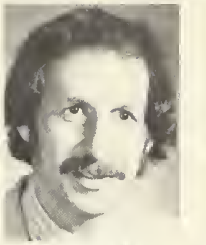
Markel

MEMBERS/Continued

guest lecturer at the 15th Congress of the International College for Foot Surgery in Lausanne, Switzerland, and chairman of the 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity sponsored by the American Society for Surgery of the Hand ... Family physician **John Neuman, MD,** was featured recently in the *Lansing State Journal* for his many hobbies, including gardening, canning, gourmet cooking and needlework. ... **Robert S. Holm, MD,** Kalamazoo, recently was elected secretary of the Kalamazoo chapter Chairman's Committee of the American Academy of Pediatrics ... Alpena surgeon **Frederick O'Dell, MD,** has been elected to the board of directors of the Michigan Division of the American Cancer Society ... **Marcia Potter, MD,** has retired at the age of 77. Doctor Potter established a family practice for 40 years in Ypsilanti ... **Doctor and Mrs. Joseph Markel,** were named honorees by the Shaare Zedek Hospital in Southfield. The Markels established an endowment for a scholarship investment fund at Shaare Zedek's school of nursing ... **Robert Tretheway, MD, David Atkinson, MD,** and **Beryl Lee, MD,** were appointed to the medical control board of Dickinson County Hospital in Iron Mountain. The medical control board will establish necessary medical protocol for a paramedi system there ... **Anne Young, MD, PhD,** Ann Arbor, has travele annually to Venezuela since 198 to study Huntington's disease. Doctor Young, an associate professor at the University of Michigan, joins members of the Venezuelan Cooperative Huntington's Disease Project each spring in Lake Maracaibo, Venezuela ... **Stevo Julius, MD,** professor of internal medicine a the University of Michigan, received the Astra Award from th International Society of Hypertension, Doctor Julius was cited for helping clarify the action of number of drugs important in treating hypertension. Honored for their 50 years of medical practice in Berrien County were: **Noe J. Hershey, MD, Frank A. King, MD, Edwin Irgens, MD, Mauric Urist, MD, Harvey Kelsall, MD, John B. Leva, MD, Hazel Eldson MD, Robert Reagan, MD,** and **Fred Henderson, MD.** Forty-thre physicians in Berrien County wer recognized for 30 years of servic each ... ☐

MEDICAL NEWSFRONTS

MSU scientists develop alternative to amniocentesis

A new, safer, quicker, less expensive way of checking developing fetuses for genetic abnormalities has been developed at Michigan State University. The technique, developed by Prof. Harold Miller and Prof. Harold Sadoff, has the potential for replacing amniocentesis, the technique currently used 500,000 times a year in the US.

ATA — alternative to amniocentesis—involves nothing more hazardous than drawing a blood sample from a pregnant woman and is effective when the fetus is only 8 weeks old. ATA involves sorting trophoblasts from the mother's red blood cells. Because the trophoblasts have the same genetic characteristics as the fetus, an examination of these cells reveals the same information as cells withdrawn from the amniotic fluid.

The key to ATA is an antibody which latches on to trophoblasts and makes them flouresce as they pass through a commercial cell sorter. About 10,000 trophoblasts can be obtained from a typical blood sample. They can then be grown in tissue culture to increase the number available for analysis.

"ATA," said Miller, "would make it possible to routinely test all pregnant women for fetal abnormalities, but new techniques need to be developed for conducting analysis of the cells. At present, making karyograms is a painstaking procedure. Only about 2,000 a year can be done by an individual technician."

Sadoff added, "We are looking at ways of speeding up the process and also of routinely analyzing the DNA within the chromosomes. It should also be possible to use ATA as a basis for checking for genetic disorders such as sickle cell anemia, as well as infectious and cellular disorders."

Health and service program for homeless

Two of the nation's largest foundations have selected coalitions in 18 major cities including Detroit, to receive nearly $25 millio to implement model health and social service programs for homeless people.

The Robert Wood Johnson Foundation and The Pew Memorial Trust will fund the Health Car for the Homeless Program whic is co-sponsored by the US Conference of Mayors. Under the program, public and private agencies will develop community-based efforts to deliver health and social services to up to 10,000 homeless people annually in each city.

Continued on page 165

When does two equal four?

When you prescribe

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Two capsules of Velosef 500 mg BID can be as effective as 250 mg QID — four capsules — of the leading oral cephalosporin… decide for yourself!

Velosef provides BID effectiveness in upper and lower respiratory tract infections… in urinary tract infections, including cystitis and prostatitis… in skin/skin structure infections when due to susceptible organisms.

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☐ Five (5) Grand Prizes… OFFICE COMPUTER DIAGNOSIS CENTER… an IBM-PC computer with software that encompasses hundreds of diseases, thousands of symptoms! A $5,600.00 value!

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Just complete and return the attached reply card!

OFFICIAL RULES: "Computers in Health Care Drawing"
NO PURCHASE NECESSARY.
(1.) On an official entry form handprint your name, address and zip code. You may also enter by handprinting your name, address and zip code and the words "Velosef–Computers in Health Care" on a 3" x 5" piece of paper. Entry forms may not be mechanically reproduced. **(2.)** Enter as often as you wish, but each entry must be mailed separately to: "COMPUTERS IN HEALTH CARE DRAWING," P.O. Box 3036, Syosset, NY 11775. All entries must be received by September 9, 1985. **(3.) Winners will be selected in random drawings from among all entries received by the National Judging Institute, Inc., an independent judging organization whose decisions are final on all matters relating to this sweepstakes. All prizes will be awarded and winners notified by mail. Only one prize to an individual or household. Prizes are nontransferable and no substitutions or cash equivalents are allowed. Taxes, if any, are the responsibility of the individual winners. No responsibility is assumed for lost, misdirected or late mail. Winners may be asked to execute an affidavit of eligibility and release. (4.)** Sweepstakes open only to physicians residing in the U.S.A., except employees and their families of E.R. SQUIBB & SONS, INC., its affiliates, subsidiaries, advertising agencies, and Don Jagoda Associates, Inc. This offer is void wherever prohibited, and subject to all federal, state and local laws. **(5.) For a list of major prize winners, send a stamped, self-addressed envelope to: "COMPUTERS IN HEALTH CARE" WINNERS LIST, P.O. Box 3154, Syosset, NY 11775.**

VELOSEF® CAPSULES
Cephradine Capsules USP

VELOSEF® FOR ORAL SUSPENSION
Cephradine for Oral Suspension USP

DESCRIPTION: Velosef '250' Capsules and Velosef '500' Capsules (Cephradine Capsules USP) provide 250 mg and 500 mg cephradine, respectively, per capsule. Velosef '125' for Oral Suspension and Velosef '250' for Oral Suspension (Cephradine for Oral Suspension USP) after constitution provide 125 and 250 mg cephradine, respectively, per 5 ml teaspoonful.

INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Can two really equal four?

Find out today and participate in the VELOSEF® Capsules (Cephradine Capsules USP) "Computers in Health Care Drawing."

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☐ Please send me a clinical trial supply of 40 Velosef Capsules 500 mg and enter my name in the "Computers in Health Care Drawing."

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ALL ENTRIES MUST BE RECEIVED BY SEPTEMBER 9, 1985.

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VELOSEF® Capsules (Cephradine Capsules USP) | BID

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Guide for adult immunization

A handbook that will help physicians meet the vaccination needs of adult patients has been published by the American College of Physicians (ACP).

"The routine immunization of children has virtually eliminated many vaccine-preventable diseases in the United States," said ACP Executive Vice President Robert H. Moser, MD, FACP. "Unfortunately, this does not guarantee the disappearance of diseases like tetanus and rubella, and many of the cases we still see are among adults."

According the the ACP's **Guide for Adult Immunization**, 88 percent of hepatitis B cases reported with known ages in 1982 occurred in people older than 20. An estimated 20 percent of young adults are not immune and may be susceptible to measles, a disease which leads to greater complications for adults than for children. And although the number of cases of tetanus has dropped sharply in the United States, virtually all of the 75-plus cases per year that do occur are in adults who have not been properly immunized. For more information, contact the American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104.

Reye's Syndrome update

No new cases of Reye's Syndrome (RS) have been reported in Michigan children since January 7. The total number of RS cases reported to date for Michigan stands at two with one death.

The only report of flu-like illness received so far this RS season has come from the southwestern portion of the state. No influenza virus isolates have been obtained yet from Michigan residents by the Michigan Department of Public Health virology laboratory. The nearby Chicago area reported outbreaks of type A (H3N2) influenza earlier in the season.

Continued on page 166

SMS Conference on

SPORTS MEDICINE

April 11, 1985
at Weber's Inn, Ann Arbor

It's a day-long conference for coaches, athletic trainers and physicians.

The subjects to be covered are drug use and abuse in athletes, throwing arm injuries, joint problems, acute eye injuries, dental & facial injuries and skin diseases in the athlete. Contact Sherry Fent, MSMS headquarters for details. (517) 337-1351.

Laminin an aid in cancer defense

A University of Michigan Medical School researcher is investigating laminin, a protein that may be a "biological glue" between cells, and may provide a key to boosting the body's natural defenses against cancer.

Thomas K. Huard, PhD, assistant research scientist in the department of internal medicine's division of hematology/oncology, has received a $168,124 grant from the American Cancer Society. He is studying how laminin influences interactions between cancer cells and macrophages.

"We know," says Huard, "that there are receptors on the surface of these white blood cells that recognize and bind laminin, and that there are laminin molecules on the surface of malignant tumor cells. We theorize that the white blood cells may be able to recognize and attach to the tumor cells by using the laminin receptor. Boosting the laminin receptors on white blood cells may be one way to make these white blood cells more efficient at attacking and eliminating the cancerous tumor cells."

Huard suggests that laminin may also influence the normal migratory behavior of these monocytes.

Monocytes find their way into the lungs, intestines and liver where, as macrophages, they ingest viruses, bacteria and cellular debris. In their normal migration to these sites, the monocytes seem to recognize and bind to laminin as a means of slipping through the blood vessel wall into their target organs. Thus, according to Huard, these white blood cells may use the laminin receptor both to fight a disease like cancer and to carry out normal cell functions.

Respiratory disorders and smoking

Henry Ford Hospital's Pulmonary Clinic has been awarded an eight-year, $2.5 million federal grant to study the effects of early treatment of respiratory disorders associated with smoking. The study entitled "Early Intervention in Chronic Obstructive Pulmonary Disease," will involve a number of other medical centers and is being funded by the National Heart, Lung and Blood Institute.

The study is designed to determine if early treatment of smokers who have developed mild abnormalities in lung functioning will prevent further decline of that function and subsequent emphysema. Subjects will be randomized to receive special treatment or usual care. Special treatment will involve aggressive smoking-stopping efforts and the use of bronchodilators.

The study will involve 650 subjects at each treatment center with recruiting to begin this fall.

According to William Conway MD, principal investigator, "Our new study could have an impac on disease prevention program particularly of health maintenanc organizations. If our study show

Continued on page 16

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that intervention does prevent disease, it could result in a new preventative treatment therapy."

Cancer patients remiss in following drug treatments

A major problem in treating cancer is patients' failure to take the drugs prescribed for them, a study at the University of Southern California suggests. Preliminary findings show that patients followed doctor's orders for taking their pills as little as 15 percent of the time.

"The problem deserves serious attention," said Alexandra Levine, MD, principal investigator. "Noncompliance represents a tragic waste, because so many diseases—including various types of cancer — are curable with chemotherapy. The problem not only affects the survival of individual patients; it can interfere with the design and proper evaluation of effective drug treatments."

The study did not address the reason why cancer patients don't take their medicine, but Levine suggests a number of possibilities.

"It could be that they're paralyzed with fear. That's the kind of effect cancer has on people in this country. Various side effects of cancer chemotherapy, such as nausea and hair loss, might also act as deterrents.

"What's more, we can't guarantee that cancer chemotherapy will work — unlike drug treatments for most other diseases. So, the patient is being told, 'Take the medicine. It will cause side effects. We don't know if it will help.' "

In an attempt to improve compliance, the USC study is testing a number of strategies to help patients follow instructions: One strategy uses slide-tape presentations to educate patients about their disease, the chemotherapy used and the patients' responsibilities; a second strategy provides social support in the home. A nurse visits the home and establishes a three-way contract with the patient and a support person in the family.

The study's preliminary findings suggest that educational and support strategies do make a difference. Compliance jumped from 15 to 50 percent in a group of 19 patients who were exposed to the two strategies.

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Help patients to better breathing

An aid to simplify and improve the rehabilitation of patients with emphysema and chronic bronchitis now is available from the American Lung Association. "Help Patients to Better Breathing - Instructor's Manual" is a guide which may be useful for training and teaching chronic lung disease patients how to live with their disease, improve their health and well-being and enhance their lifestyles. The manual is a step-by-step guide which includes suggested lesson plans, metho of group discussion, a patient progress record, sample patient materials and references to additional materials available on lung disease. The three-ring binder includes a videotape, either 3/4" or VHS format. For more i formation call toll free 1-800-292-5979, or write to America Lung Association of Michigan, 403 Seymour Avenue, Lansing 48914.

AIDS study

The city of Detroit will serve as control area in a University of Southern California School of Medicine AIDS study.

The project, funded for five years by the National Heart, Lun and Blood Institute of the National Institutes of Health, is the largest single study thus far devoted to AIDS.

The research will be directed by a USC professor of medicine and will be carried out by researchers at participating institutions in six cities. Four cities — New York City, San Francisco, Lo Angeles and Miami — were chosen for their high incidence of AIDS cases. The other two — Detroit and Seattle — report a low incidence and will serve as control areas. Children's Hospital o Michigan and Wayne State University are the local participatin institutions.

The series of studies on the transmission of AIDS through blood transfusions will focus pa ticular attention on patients wit hemophilia.

One of the project's primary objectives is to evaluate a bloo screening test that has been under development since the virus (HTLV-III) thought to caus AIDS was identified last April. When the screening procedure becomes available — most like in four to six months — it will used to test samples of blood previously given by 200,000 donors. The researchers will th follow as many as 400 people who are identified as previous recipients of blood transfusions

Continued on page 17

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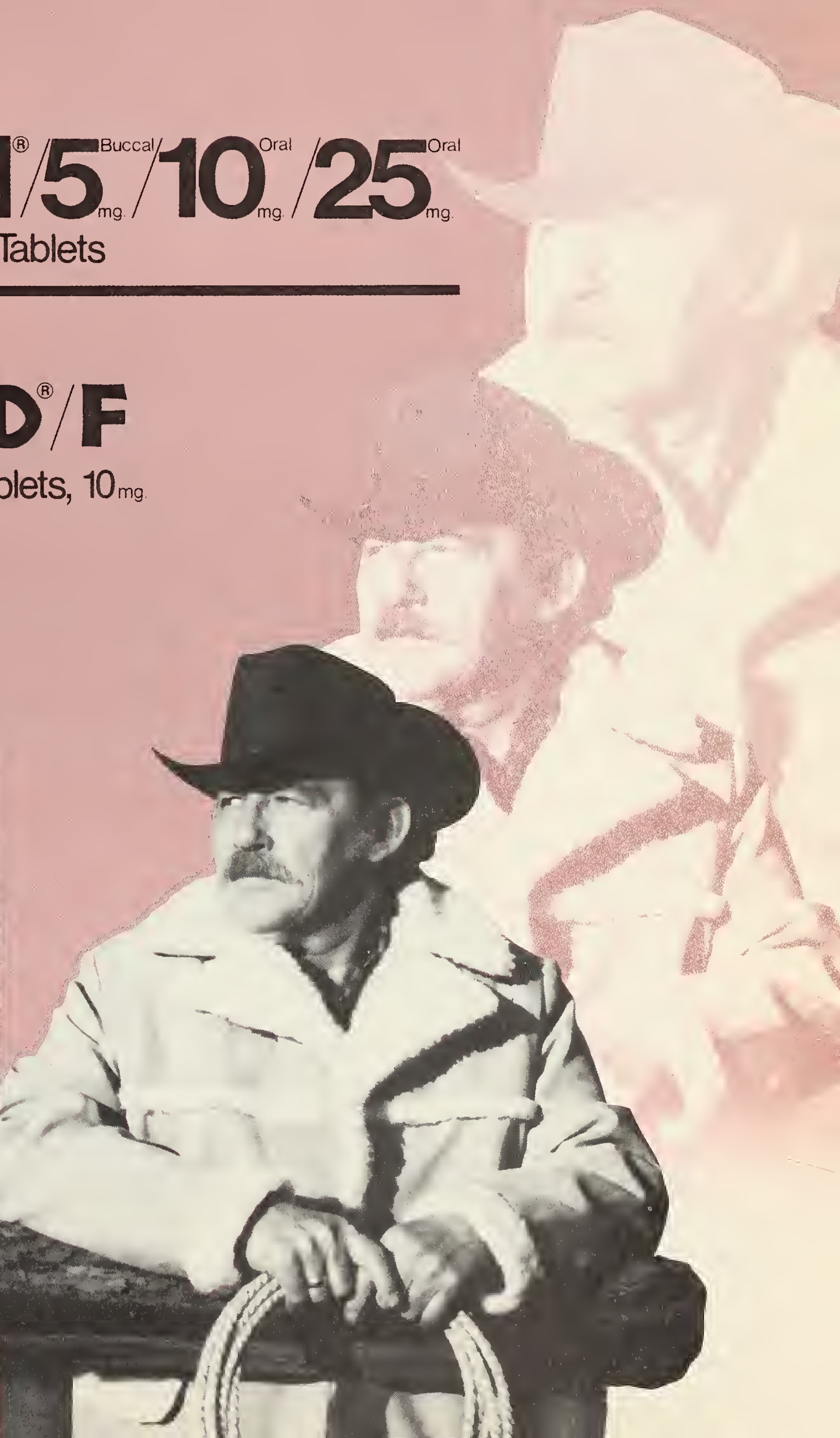

containing antibodies for the AIDS virus.

AIDS case reports from 1979 to October 1, 1984 from the Center for Disease Control, Atlanta: Total cases - 6,251; Total deaths - 2,950. Percentage of total cases by group: Homosexual and bisexual men - 73%; Intravenous drug users - 17%; Haitians - 4%; Hemophiliacs - 1%; Others - 5%. Cases in males - 5,823; cases in females - 428.

Primary disease: Kaposi's sarcoma only - 1,479 cases (436 deaths); Kaposi's sarcoma and pneumocystis carinii - 379 cases (254 deaths); Pneumocystis carinii only - 3,358 cases (1,695 deaths); Other opportunistic infections only - 1,035 cases (565 deaths).

Drug resistance

When it comes to spreading drug resistance and certain other characteristics, bacteria may transfer genes by "mating." The trigger for this mating-like activity is a sex pheromone, customarily observed as a stimulating scent in higher life forms, says Don B. Clewell, Ph.D., professor in the U-M's School of Dentistry and Medical School. Bacterial sex pheromones were discovered just a few years ago by Clewell's research team.

"Our new findings will provide a basis for further investigation of the genes that encode the sex pheromone," Clewell says, "and we hope this provides some insight into how cells communicate."

Clewell and his associates have found that strains of Streptococcus faecalis that are resistant to antibiotics are statistically more likely to be producers of sex pheromones. Heightened drug resistance has led to an increase in some forms on meningitis and in salmonella and staphylococcus infections. "As drug resistance grows, understanding the mechanisms of resistance and how bacteria acquire them becomes more important in controlling them," he said.

Book explores food allergies

A new 321-page monograph entitled "Adverse Reactions to Foods" has been produced jointly by the American Academy of Allergy and Immunology and the National Institute of Allergy and Infectious Diseases. This book is appropriate for medical practitioners and clinical investigations and is based on published medical literature.

Edited by John A. Anderson, MD, and Dorothy D. Sogn, MD, the monograph has 24 contributors who cover such topics as chemistry of selected food antigens, the fate of food antigens in the digestive tract, immunologic and nonimmunologic food reactions, diagnosis and treatment of adverse food responses, and avoidance of specific foods, prior to known sensitization, in potentially susceptible infants. There is also an extensive appendix listing diseases tramsmitted by foods.

Adverse Reactions to Foods (Stock No. 017-044-00045-1) can be purchased by mailing a check or money order for $9.50 to the Superintendent of Documents, US Government Printing Office, Washington, DC 20402. Be sure to specify the stock number with your order. ☐

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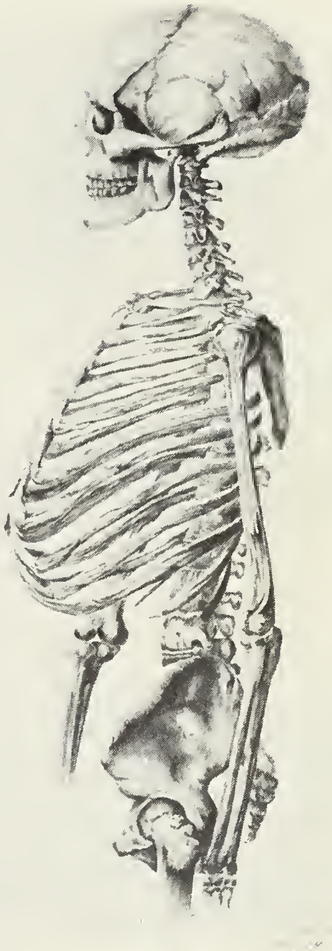

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MSMS leaders continue a productive dialogue about solving malpractice problems

An MSMS task force led by President Louis R. Zako, MD, left, agreed Jan. 30 to investigate implementation of a pilot program testing a "selective no fault" medical malpractice insurance proposal for Michigan. The task force, which includes Frederick V. Minkow, MD, Pontiac, right, reported t the MSMS Board March 6.

The no fault proposal is the idea of University of Virginia law professor Jeffrey O'Connell, right, who described the details of his proposal at a meeting at Detroit Metropolitan Airport that day. Among the group were, from left, Robert M. Leitch, MD, Battle Creek, president, Michigan Physicians Mutual Liability Company, and William Madigan, MSMS managing director. MPMLC and the MSMS task force will work out procedural and contractual aspects of the proposal, and the MPMLC board will decide whether to implement the no fault plan.

Professor O'Connell describes how his pl would work.

Photos by Rod Reiser, Detroit
and Dennis Craft, Marshall

oda M. Powsner, MD, Ann Arbor, right,
mber, Advisory Committee to the Michigan
bitration System, stressed the seriousness
the malpractice insurance situation for
chigan physicians. She and Professor
Connell chatted before the meeting at the
rriott Hotel at the airport.

MSMS, in its quest for solutions to the medical malpractice insurance crisis, met recently with the representatives of the three major physicians' insurance carriers in the state. Above, from left, MSMS board Vice Chairman Carl A. Gagliardi, MD, and President-elect Richard J. McMurray, MD, listen while John F. Dodge, legal counsel for Physicians Insurance Company of Michigan describes PICOM's view of the problems and possible solutions.

the table at the February 6 meeting, from left, were William G. Olsen,
COM president; Arthur B. Eisenbrey, MD, PICOM Board member; David
Murray, vice president, Medical Protective Company, and Michael S. Mul-
n, executive vice president, Medical Protective Company. There was gen-
al agreement to support the Michigan Arbitration Program, and to con-
ue dialogue toward other solutions.

By Nancy Crandall

Auxiliary — what a bargain

As members of a nationwide, federated auxiliary, we have a responsibility to be aware of its programs and positions. Information is sent to each member to describe state and national auxiliaries, their purposes and activities. But, as members we also should be knowledgeable about how all these varied activities are financed.

Each year more than 80,000 physician spouses across the country pay $15 each for national dues. In 1984-85 this represents a $1.2 million budget. Each $15 dues payment is distributed among four areas: $4.57 is spent in federation support of annual convention activities, board and committee meetings, reports, national representatives to state and county meetings, mini-confluences, workshops, consultations and membership recruitment and retention; $3.50 is spent for educational opportunities such as the annual Leadership Confluence and the Professional Skills Development Program; $3.04 goes for information and research projects, including package programs, Project Bank, pamphlets on health topics, meeting reports, resource materials, and research personnel; $3.15 is spent for periodic publications including *Facets* and *Facets Newsletter* (sent to all members), *National News, Direct Line Newsletter* (to 4,000 resident physician and medical student spouses); and finally, $.74 is for public affairs efforts involving cooperation with other organizations and representation at AMA meetings of AMA and other health-related issues.

This brief summary of the disposition of our $15 points out two things: there is a tremendous amount of activity and accomplishment for a very small amount of money; and we as individual Auxilians and as members of county auxiliaries are beneficiaries in every area of national endeavor.

In Michigan, we pay $10 annual dues to our state organization. Along with a subsidy from the MSMS which helps finance our annual convention, this amounts to a budget for 1984-85 of $25,455. Forty-one percent of the budget is spent for officers' expenses; 20 percent is spent for standing committee expenses including legislation, AMA-ERF, education and materials; 11 percent is spent for educational meetings including our annual session and mini-confluence; 1 percent is for donations including support of the Michigan Health Council, World Medical Relief, Michigan Child Passenger Safety, and Project Hope; and 27 percent is for expenses including transportation of our county presidents-elect to Chicago for Confluence and of our AMA Auxiliary delegates to the yearly AMA/A annual session; and for publication of the *Auxilium*.

Upon examination, it is very apparent that dollar for dollar, MSMS/A membership truly is a bargain! ☐

Mrs. Crandall, Muskegon, is MSMS/A president.

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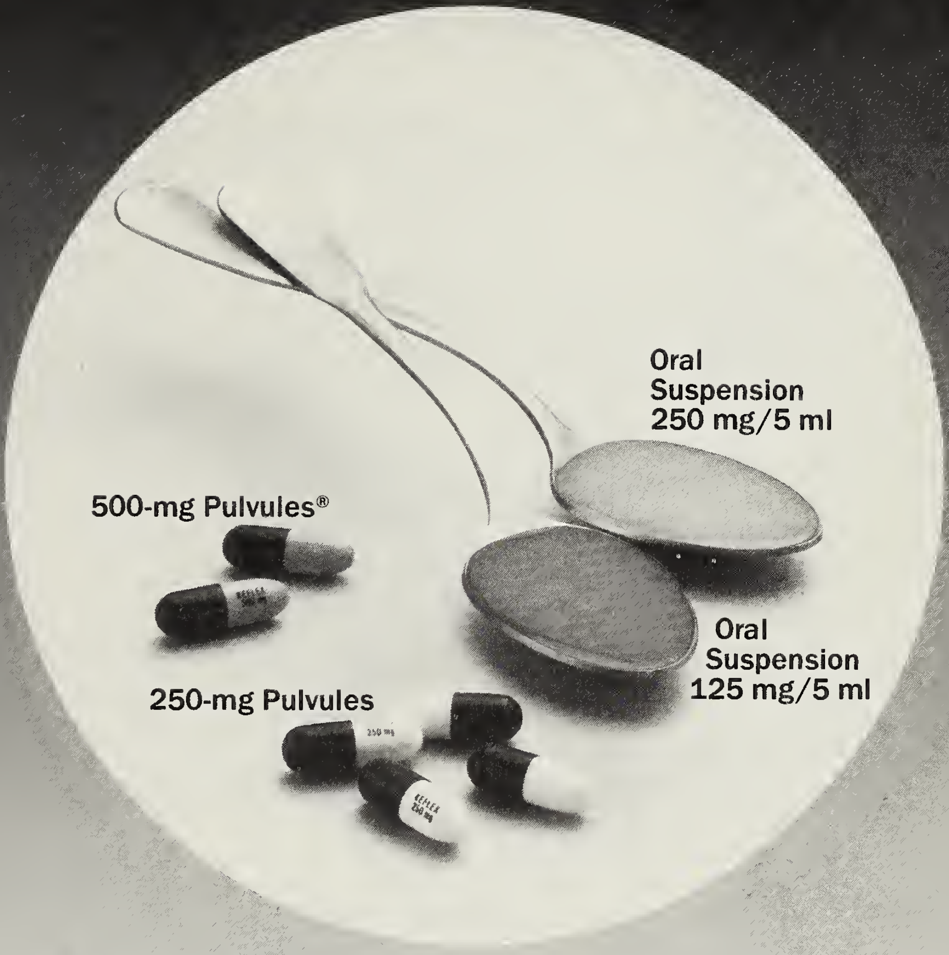
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Seat belt sponsor Cruce on the new

Senator Doug Cruce listened in his red-carpeted capitol building office as the piercing bell reverberated through the century-old structure. He sat bolt upright in his chair.

The bell, sounding to bring House members to the floor for a vote, was Cruce's cue to get to the chamber to help shepherd through his mandatory seat-belt bill. After more than two long years of work on the Senate-passed measure, he desperately wanted to see it finally happen—passage by both chambers.

And it happened. The House passed SB6 February 19, by a 64-41 margin—a margin wide enough to put the new law into immediate effect (July 1, 1985). Michigan is the fourth state to enact such a law, behind Illinois, New Jersey and New York.

Why was the 38-year-old, moderate-to-conservative Republican senator from Troy such a proponent of a bill that opponents label as Big Brotherism and government intrusion into private lives? After all, he is no flaming liberal yearning to see government fingers in everyone's pie.

Besides, he didn't even wear a seat belt until two years ago.

A seat-belt education

His conversion came when he was a member of the House Insurance Committee more than two years ago, where he served before being elected to the Senate. After months of hearings and testimony from safety experts from such places as the University of Michigan, the Michigan State Police and the Secretary of State's office, Cruce became convinced the bill was necessary.

When he was elected to the Senate, one of the first bills he introduced was the seat belt measure.

"I felt if I were a part of the activity in moving it through the legislature then some of the more conservative members would take a closer look at it and it would be much easier to pass with my support," he said, leaning back in his leather chair, perhaps savoring the battle won, "And that is what happened."

He wears a seat belt "every second I'm in the car" as a result of his seat belt education.

"It's a matter of habit," he offered. "I'm thoroughly convinced that all of the opposition to the law is going to be viewed several years from now as much ado about nothing. It's such a simple matter to buckle that seat belt and the benefits are so numerous that not to give it a try doesn't make any sense."

One of the arguments Cruce hears is that government has no right to intrude into the matter.

"When people say they have the right (not to wear seat belts what they're saying is they hav the right to throw themselves through the windshield whenev they want to," he countered. H added if the driver was the onl person affected, maybe that argument has some merit.

However, Cruce maintains th driver is also responsible for th other passengers in the car in addition to pedestrians and/or other motorists. "You begin to realize it's not an individual choi matter."

Cruce continued that society ends up paying for accidents caused by drivers not wearing seat belts through such ways a added insurance costs, and higher Medicaid or Medicare costs.

Summary of the law

The law amends the Michiga Vehicle Code to require drivers and front seat passengers of ve hicles to wear properly fastene seat belts. Passengers under fo years old would be subject to t code's current requirements, (i fants less than a year old must be in a federally-tested child re strant seat; children between o and four years of age must be either in a federally-tested chil restraint seat or secured by a ba seat seat belt). Drivers would b required to see that children b tween the ages of four and 16 were properly secured with a belt.

Violation of the law's provisio is a civil infraction carrying a maximum fine of $10 until Jan ary 1, 1986. After that date, th fine and court costs are $25. Vi

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Ms. Eberly is a Lansing area freelance writer.

By Carole Eberly

and his job

tors are not assessed points nor
the infraction placed on their
iving records. Failure to wear a
elt can be considered evidence
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rm the ownership, mainte-
nce, or operation of a vehicle,
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cation from a physician that they
e unable to wear a belt for phys-
al or medical reasons also are
t required to wear belts. The
w does not apply to school bus
ssengers.

home in the Senate

Cruce sat behind a large walnut
esk in a spacious office deco-
ted with wooden beams over-
ad and tan wall-papered walls.
sofa at one end of the office rests in front of a small window from which he can see the statue of Austin Blair, the Civil War governor, at the start of the Capitol's walkway. A bookcase behind his desk is filled with Michigan Public Acts and other legislative-type reading matter.

Cruce appeared very much at home in the surroundings. But, after serving two years in the House, and then being elected to the Senate in 1982, does he want to move on again?

"I think the best way to move ahead is to do the best you can at what you're doing at the moment and I think that this seat belt law is a good example," he reflected.

"I just focused my entire attention on it to get it passed. Whatever I do now and whatever I accomplish will lay the groundwork for me to move ahead. Without having any specific plans, that's the best I can say about the future."

Although Cruce had no specific plans for the future, he did have some specific praise for the ongoing breakfast meetings with Oakland County physicians.

"They are a great service to us (lawmakers) in getting the input of a wide range of divergent interests within the medical profession," he said. "There are psychiatrists, pediatricians, gynecologists and others who all have their own sphere of interest. Sometimes a person speaking for the medical profession is only speaking for his own little area in the medical profession. By going to those meetings I find it's much more likely that I'm going to get a broader opinion and point of view of what the profession's outlook is on a particular bill."

He said the physicians are free to pick up their phones and call Cruce confident that "I know who they are.

"The best thing that any group can do is to have access," he continued. "The key is access. If you don't have access you can never state you case."

Looking out for the public

He believes the medical profession has a good reputation of looking out for the general interest of the population. And, if there's a medical issue that he needs knowledge or backgound on, then physicians have a right and obligation to inform him.

"And it's easier for them to do, if they kow who we (legislators) are," he added.

He also wants his general constituents to know who he is.

He holds town hall meetings from time to time in his district to find out what voters are thinking.

"I have a great involvement in answering my mail," he said, holding a sheet of paper in front of him containing squares of typed material. "I get a weekly list of all the letters we have received—what the subject matters were and what our response was (which he formulates). I need to know how many letters we did get on a particular subject.

"With this type of report, I have a pretty good feel for what's happening and it keeps me closer to the district," he said.☐

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That the Michigan State Medical Society offers a Business Overhead Insurance plan for MSMS members!

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If you would like additional information about the Michigan State Medical Society group Business Overhead plan and how to apply, please return the form below. This is another MSMS member benefit available to you.

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BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances
potent
coronary
vasodilation
with a low
incidence of
side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

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42% to 46% decrease reported in multicenter study.[1]

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In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

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(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page. 2/84

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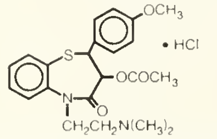
PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), ras asthenia (1.2%), AV block (1.1%). In addition, the followin were reported infrequently (less than 1%) with the order of p tion corresponding to the relative frequency of occurrence

Cardiovascular:	Flushing, arrhythmia, hypotension, dia, palpitations, congestive heart syncope.
Nervous System:	Paresthesia, nervousness, som tremor, insomnia, hallucinations, and
Gastrointestinal	Constipation, dyspepsia, diarrhea, mild elevations of alkaline phosphatas SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photos
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing epi vasospastic angina developed periods of transient asym asystole approximately five hours after receiving a singl dose of CARDIZEM.

The following postmarketing events have been report quently in patients receiving CARDIZEM: erythema multifo kopenia; and extreme elevations of alkaline phosphatas SGPT, LDH, and CPK. However, a definitive cause and effect these events and CARDIZEM therapy is yet to be establis

OVERDOSAGE OR EXAGGERATED RESPONS

Overdosage experience with oral diltiazem has been Single oral doses of 300 mg of CARDIZEM have been well by healthy volunteers. In the event of overdosage or exa response, appropriate supportive measures should be em addition to gastric lavage. The following measures may be co

Bradycardia	Administer atropine (0.60 to 1.0 mg) is no response to vagal blockade, a isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fix degree AV block should be treated diac pacing.
Cardiac Failure	Administer inotropic agents (isopr dopamine, or dobutamine) and diureti
Hypotension	Vasopressors (eg, dopamine or lev bitartrate).

Actual treatment and dosage should depend on the sever clinical situation and the judgment and experience of the physician.

The oral/LD_{50}'s in mice and rats range from 415 to 74 and from 560 to 810 mg/kg, respectively. The intravenous these species were 60 and 38 mg/kg, respectively. The or dogs is considered to be in excess of 50 mg/kg, while leth seen in monkeys at 360 mg/kg. The toxic dose in man is n but blood levels in excess of 800 ng/ml have not been as with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerot nary Artery Disease or Angina Pectoris at Rest Due nary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before mea bedtime, dosage should be increased gradually (given i doses three or four times daily) at one- to two-day inter optimum response is obtained. Although individual pati respond to any dosage level, the average optimum dosa appears to be 180 to 240 mg/day. There are no available data ing dosage requirements in patients with impaired renal o function. If the drug must be used in such patients, titration s carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to ab anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may coadministered with short- and long-acting nitrates, have been no controlled studies to evaluate the an effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 1 0088-1771-47) and in Unit Dose Identification Paks of 1 0088-1771-49). Each green tablet is engraved with MARIO side and 1771 engraved on the other. CARDIZEM 60-m tablets are supplied in bottles of 100 (NDC 0088-1772-47) a Dose Identification Paks of 100 (NDC 0088-1772-49). Ea tablet is engraved with MARION on one side and 1772 on

Issue

Another patient benefit product from

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CALCIUM CHANNEL
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(diltiazem HCl)
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THE BALANCED
CALCIUM CHANNEL BLOCKER

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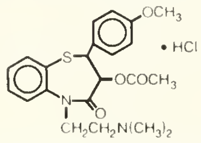

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PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rasl asthenia (1.2%), AV block (1.1%). In addition, the followir were reported infrequently (less than 1%) with the order of tion corresponding to the relative frequency of occurrence

Cardiovascular:	Flushing, arrhythmia, hypotension, dia, palpitations, congestive hear syncope.
Nervous System:	Paresthesia, nervousness, somi tremor, insomnia, hallucinations, and
Gastrointestinal:	Constipation, dyspepsia, diarrhea, mild elevations of alkaline phosphatas SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photos
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing epi vasospastic angina developed periods of transient asym asystole approximately five hours after receiving a singl dose of CARDIZEM.

The following postmarketing events have been report quently in patients receiving CARDIZEM: erythema multifo kopenia; and extreme elevations of alkaline phosphatas SGPT, LDH, and CPK. However, a definitive cause and effect these events and CARDIZEM therapy is yet to be establis

OVERDOSAGE OR EXAGGERATED RESPONS

Overdosage experience with oral diltiazem has been Single oral doses of 300 mg of CARDIZEM have been well by healthy volunteers. In the event of overdosage or exa response, appropriate supportive measures should be em addition to gastric lavage. The following measures may be co

Bradycardia	Administer atropine (0.60 to 1.0 mg) is no response to vagal blockade, a isoproterenol cautiously
High-Degree AV Block	Treat as for bradycardia above. Fix degree AV block should be treated diac pacing.
Cardiac Failure	Administer inotropic agents (isopr dopamine, or dobutamine) and diureti
Hypotension	Vasopressors (eg, dopamine or lev bitartrate).

Actual treatment and dosage should depend on the sever clinical situation and the judgment and experience of the physician.

The oral/LD_{50}'s in mice and rats range from 415 to 74 and from 560 to 810 mg/kg, respectively. The intravenous these species were 60 and 38 mg/kg, respectively. The ora dogs is considered to be in excess of 50 mg/kg, while leth seen in monkeys at 360 mg/kg. The toxic dose in man is n but blood levels in excess of 800 ng/ml have not been as with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerot nary Artery Disease or Angina Pectoris at Rest Due nary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before mea bedtime, dosage should be increased gradually (given i doses three or four times daily) at one- to two-day interv optimum response is obtained. Although individual patie respond to any dosage level, the average optimum dosa appears to be 180 to 240 mg/day. There are no available data ing dosage requirements in patients with impaired renal o function. If the drug must be used in such patients, titration carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to ab anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may coadministered with short- and long-acting nitrates, have been no controlled studies to evaluate the an effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 1 0088-1771-47) and in Unit Dose Identification Paks of 1 0088-1771-49). Each green tablet is engraved with MARIO side and 1771 engraved on the other. CARDIZEM 60-m tablets are supplied in bottles of 100 (NDC 0088-1772-47) a Dose Identification Paks of 100 (NDC 0088-1772-49). Ea tablet is engraved with MARION on one side and 1772 on t

Issue

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arch 20-21 — Michigan Con-
rence on Maternal and Perinatal
ealth, Hyatt Regency, Dearborn,
ntact: Sherry L. Fent, MSMS
adquarters.

pril 11 — MSMS Sports
edicine Conference, Weber's
n, Ann Arbor, contact: Sherry
Fent, MSMS headquarters.

pril 26-28 — 1985 MSMS
ouse of Delegates meeting,
ichigan Inn, Southfield, contact:
chard Campau, MSMS head-
arters.

arch 29 — MSMS/A Mini-
onference for County Officers,
SMS headquarters, East Lan-
g, contact: Viola M. Heins,
SMS headquarters..

ay 6-8 — 59th Annual Session
SMS Auxiliary, Holiday Inn,
uskegon, contact: Viola M.
eins, MSMS headquarters.

ay 23-24 — MSMS Committee
Maternal and Perinatal Health
ll Lake Conference, MSU Gull
ke Conference Center, Hickory
rners, contact: Katie Brewbaker,
SMS headquarters.

ne 16-20 — Annual AMA
ouse of Delegates, Chicago,
ntact: Bruce Ambrose, MSMS
adquarters.

ly 18-20 — MSMS Board of
rectors Midsummer Meeting,
dden Valley Resort, Gaylord,
ntact: William Madigan, MSMS
adquarters.

THER MEETINGS

ril 2-5 — 27th Annual Re-
iratory Care Symposium, Hyatt
gency Hotel, Dearborn, con-
t: Caroline Rich, Michigan Society for Respiratory Therapy, PO Box 950, East Lansing 48823 (517) 337-1351.

April 25 — Michigan Hospice Organization Annual Meeting, Sheraton Southfield, contact: Hospice of Southeast Michigan, 22401 Foster Winter Drive, Southfield 48075.

May 2-3 — Michigan Chapter American College of Surgeons, Resident Surgeons Coller Day Competition and Scientific Session, Henry Ford Hospital and Dearborn Inn, contact: Viola M. Heins, MSMS headquarters.

May 10 — Michigan Associates of the American College of Physicians Meeting, Marriott Inn, Grand Rapids, contact: Arnold R. Axelrod, MD, FACP, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235.

May 15 — Michigan Allergy Society Executive Committee Meeting, University of Michigan, contact: David Seaman, MD, Secretary, Michigan Allergy Society, 8578 Canton Center Road, Canton 48187 (313) 453-2661.

May 17-19 — Michigan Association for Medical Education Annual Meeting, Hilton Shanty Creek, Bellaire, contact: Viola M. Heins, MSMS headquarters.

May 17-19 — Michigan Society of Pathologists Scientific Meetings, Hyatt Regency, Flint, contact: Viola M. Heins, MSMS headquarters.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313) 839-3011.

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Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Robert W. Counts, MD
Action, Date Taken: 2 yr. Probation effective upon return to practice
Reason: Alcohol dependency - voluntarily submitted to treatment at Oxford Institute, Oxford, Michigan.

Name: Gary R. Pierce, MD
Action, Date Taken: Suspended - 1 year - December 5, 1984
Reason: Conviction of a felony reasonably related to and adversely affecting his ability to practice in a safe and competer manner.

Name: George M. Shargel, MD
Action, Date Taken: Revoked - October 19, 1984
Reason: Selling or prescribing c drugs for other than a lawful pur pose.

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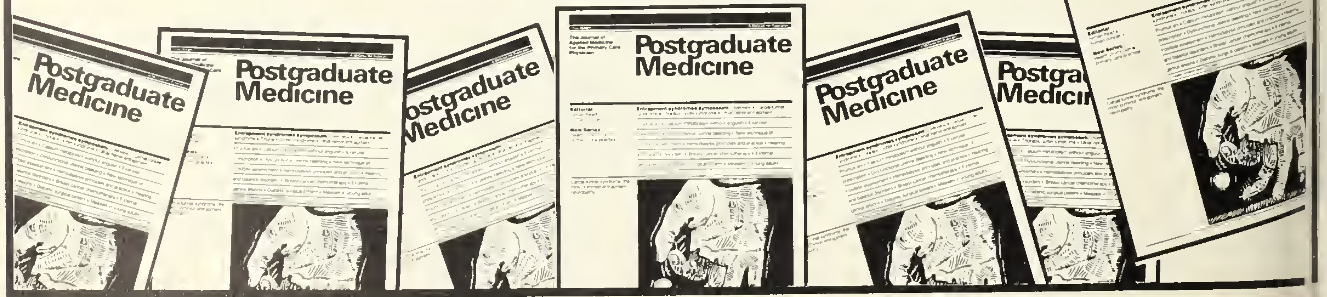

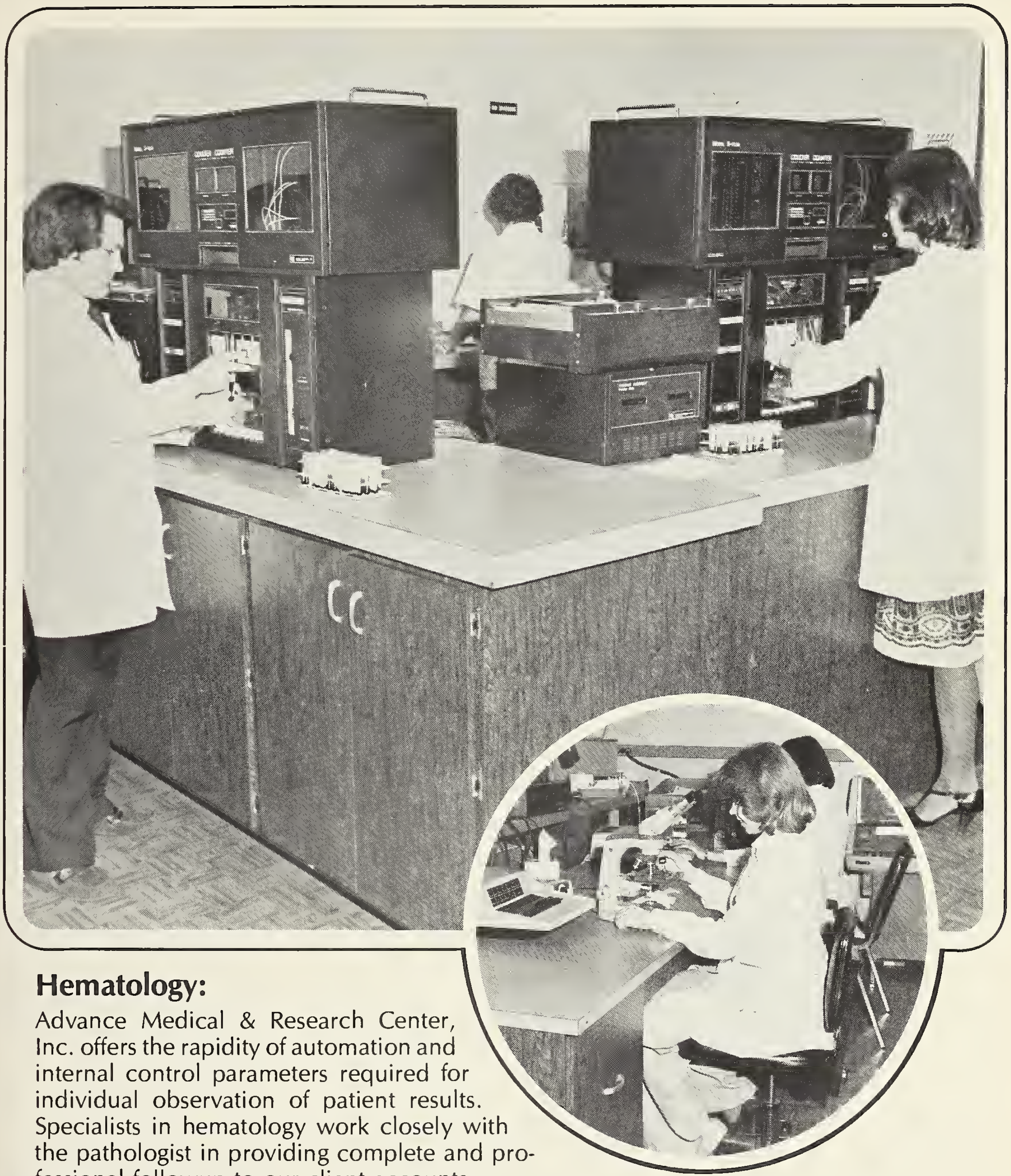

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Serving the medical profession since 1963

By Sheri Greenhoe, Managing Edit

Answers to your questions about car deductions

Much has been written and broadcast about the new rules for deducting the cost of a business auto. Medical Economics thoroughly detailed the hows and whys of tax credit, depreciation and leasing in its January 21 issue.

That article also pointed out one hard and fast rule that applies to everyone who wants to take a business car deduction: Retroactive to January 1, 1985, you must keep a special log of every trip you take — a contemporaneous record of the date, mileage, person or place visited, and business purpose. Times of arrival and departure need not be recorded.

Members have asked for answers to some specific situations they routinely encounter in their practices. Answers to some of their questions, written according to the rules as they stood at press time, are below:

- The rules state that the first trip of the day and the last trip of the day cannot be deducted. Does an emergency night call to the hospital become the last trip of the day?

One thing you must remember is that the distance from home to your workplace is not deductible. Depending on the time of day or other circumstances, the definition of a physician's workplace varies. In this case, the emergency night call to the hospital is considered the day's last trip from home to workplace, and is not deductible.

- We have a doctor who lives 30 miles from our hospital. Is his first call to the hospital in the morning deductible?

Again, the first trip of the day is not deductible. If this doctor first goes to his office, then on to the hospital, the trip between his office and the hospital (the second trip of the day) is deductible.

- So, is a five minute stop at the office on the way to a long trip to the hospital deductible?

No, again, the short trip to the office was the first trip to the workplace.

- Is a trip to the bank for office deposits or to a post office box on the way to the hospital considered a first trip?

Yes, that trip is to a work-related workplace, and is the first trip of the day and not deductibl But, the distance from the bank or post office to the hospital is deductible.

- Is a trip to a neighborhoo gas station a "first trip"?

No. "First trip" means first tri from home to workplace.

- Does an emergency room call at 4 AM become the first tri of that date, or the last trip of th preceding day?

The first trip of the day is the first one taken at 12:01 AM or later on any given date.

- On a weekend day with n office appointments, is a 60 mi round trip to and from the hospital not deductible?

Correct. The trip to the hospit was the first trip to the workplac and the trip home was the last trip. Neither is deductible.

- Are Sunday trips to church or the store, while I'm on call, wearing a beeper and ready fo work at a moment's notice, deductible?

No. Only work-related trips, other than first and last of the da are deductible.☐

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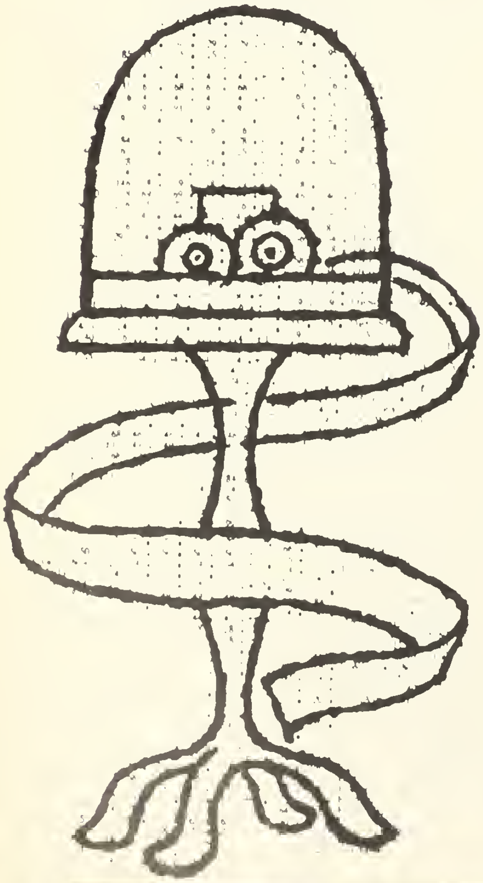
By Katharine S. Brow

What's new with IRAs?



The Individual Retirement Account continues to be among the most universally useful tax management procedures available. Most persons who have earned income (wages, salary, commissions and self-employment earnings) should contribute to an IRA. The few exceptions include taxpayers with earned income, but no tax to pay; high-income and asset persons, temporarily subject to alternate minimum tax (20 percent); and those who simply can't afford to make the contribution and tie up the money. Otherwise, the IRA will not only save taxes this year, it can be invested to compound, tax-deferred, until needed in retirement, disability or an emergency. (Note: withdrawals prior to age 59½ may be subject to 10 percent penalty.)

Ms. Brown is an account executive with Prescott, Ball and Turben, East Lansing.

Not only has the IRA been a good tax management procedure ever since its inception in 1975, but it has become bette and better over the years. This year, however, the Deficit Reduction Act of 1984 again ma changes that affect IRAs, and unfortunately not all the chang are good.

Alimony qualifies

Beginning next year, not for 1984, alimony payments will b treated as earned income and therefore qualified for contributions. Under previous law, a divorced spouse was entitled to deductions for contributions t an IRA that had been establish by the other spouse at least fi years prior to divorce and to which that spouse had contributed under the spousal IRA rul for at least three of the five ye preceding the divorce. The deduction was limited to a

Continued on page 1

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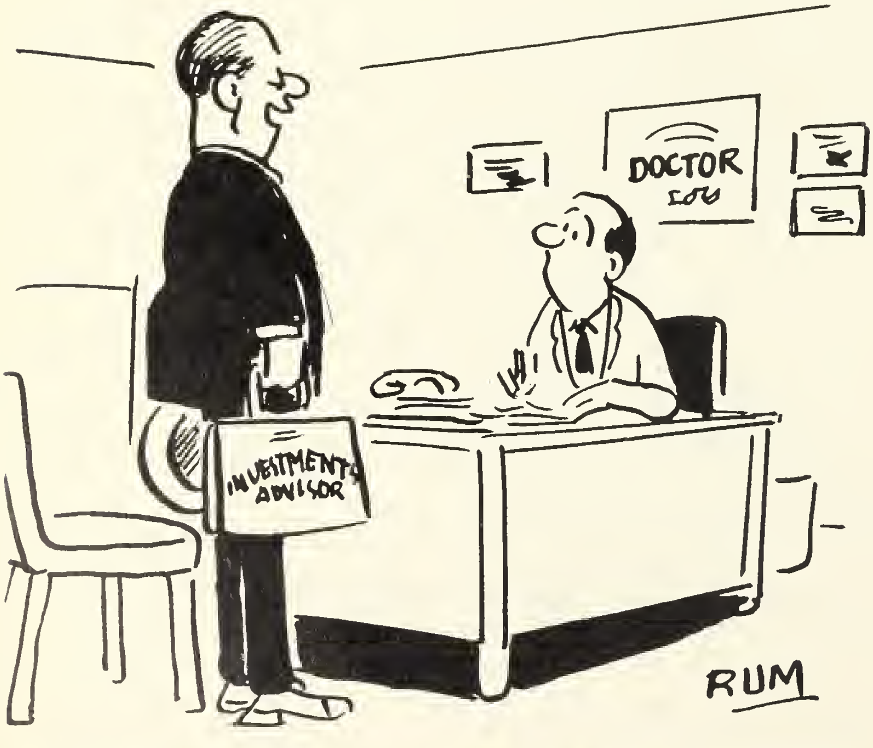
IRA's/continued

maximum of $1,125 of certain alimony payments included in the divorced spouse's gross income. Starting next year, all alimony payments will be treated as compensation and the IRA contribution/deduction allowed will be the lesser of $2,000 or 100 percent of earned income, including alimony.

This change will undoubtedly become a part of the fabric of future divorce settlements, since the first $2,000 of alimony will be deductible by both the payor and the payee. Further, it may be attractive to reduce the annual amount and to stretch out the time period of alimony payments.

Estate deduction gone

Under previous rules, up to $100,000 of qualified retirement plan benefits could be excluded from the calculation of estate taxes. Now, for decedents who die after December 31, 1984, this estate tax exclusion will be lost. Happily the combination of unlimited tax-free transfer to a surviving spouse and increasing unified credit (which will be the equivalent of $400,000 per estate in 1985) will make this change of little concern to all but the largest of estates. However, it does mean that the use of life insurance owned by children, or an insurance trust, is even more attractive as a means of escaping estate tax. Further, it is possible that the present favorable treatment afforded to "outside estate" life insurance that utilizes the "no incidents of ownership" procedure may also come under scrutiny. Hence, you may want to move ahead if you have been considering the timely transfer of certain life insurance policies to other family members, or trusts.



"One of the immediate benefits of my financial plan is that if you subscribe to it, I'll take you to lunch today."

The 1984 Act requires all 198 IRA contributions to be made b April 15, 1985. Previously, if yo filed for an extension, you coul delay the IRA contribution until you actually filed your tax retur

Stretching the payout

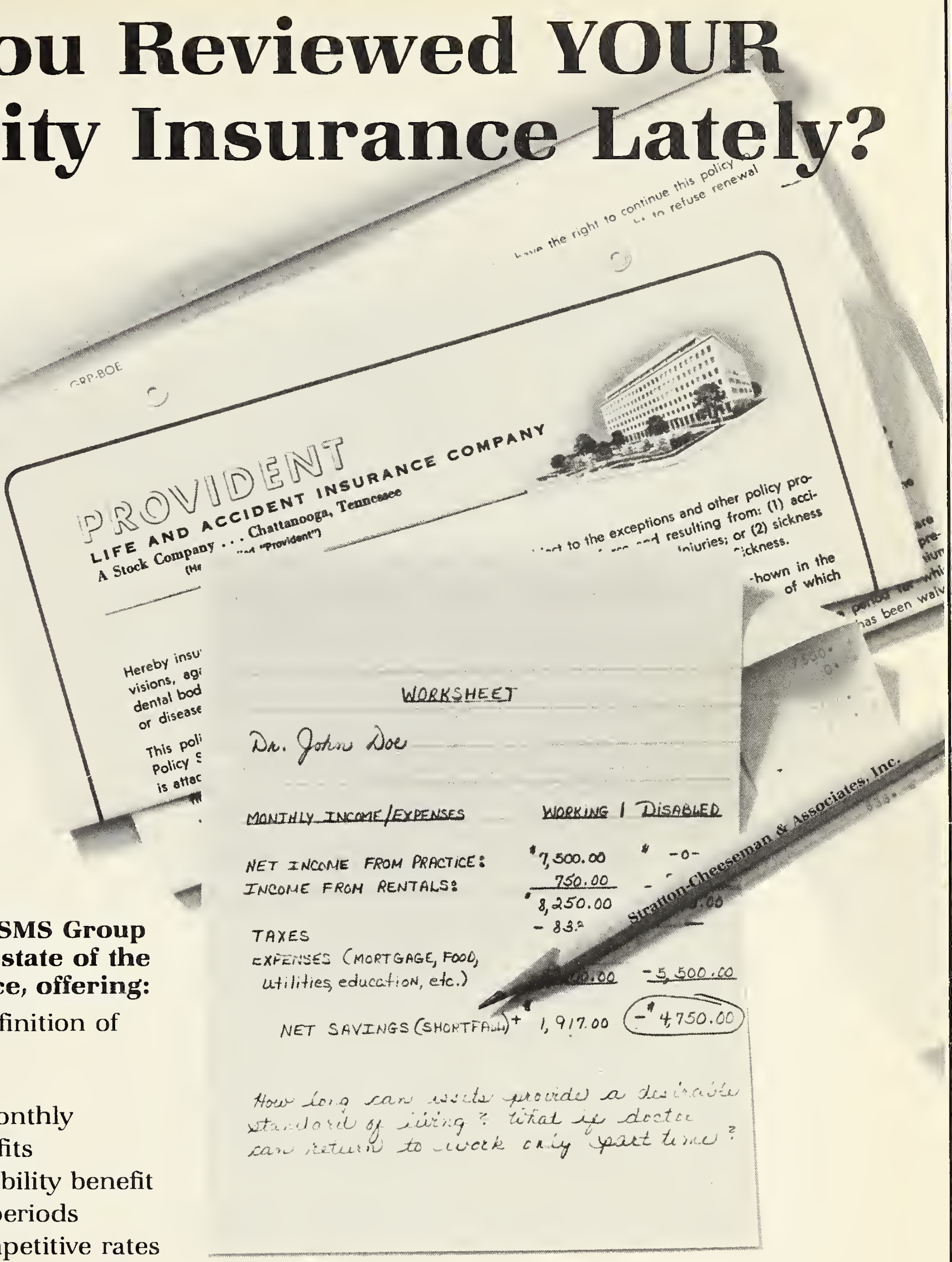
Under prior law, your statistic life expectancy at the time payments began set the minimum amount you had to receive fron your IRA for the rest of your life Beginning in 1985, the payout schedule may be recalculated a often as once a year, based upo your statistical life expectancy a that time. The longer you live, th longer your statistical life expec tancy. Thus, regular recalculatio may limit the rapid increase in re quired payout as the years go b This change not only makes the IRA more attractive where your other retirement income is likel to be substantial, but it makes th use of an IRA rollover more attractive.

Tax loss to an IRA

A self-managed IRA technicall is a separate entity even if it is your own. Thus, if you own a stock that has dropped substan tially in price, but you hesitate t sell for a tax loss because you ex pect a rally, you could sell it an simultaneously buy it in your IR You would establish a tax deductible loss for yourself, but you could still benefit from the stock's recovery, now in your IR This procedure avoids the required 31-day wait between sal and repurchase when using you own account.

Consider giving an IRA to yo employed child. Anyone who ha earned income, or, beginning i 1985, receives alimony, is qualified to contribute the lesser of $2,000 or 100 percent of such income to an IRA. If your child doesn't have the money to mak the contribution, you could pro vide the funds. Such a gift woul have two benefits; first, the money received and saved for the future; and second, the tax deduction that will be taken by the child.☐

Have You Reviewed YOUR Disability Insurance Lately?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WORKSHEET

Dr. John Doe

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INCOME FROM RENTALS:	750.00	- [illegible]
	$8,250.00	[illegible].00
TAXES	- 833	—
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.)	[illegible].00	-5,500.00
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michiga law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicat a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

Date: March 20-21, Michigan Conference on Maternal and Perinatal Health. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 13 hours of Category I Credit.

Date: March 22-23, Second Annual Chronic Pain Symposium. Location: Sheraton Fashion Square, Saginaw. **Sponsor:** Bay Medical Education. **Contact:** Dodie Roth, Bay Medical Education, 615 Ninth Street, Bay City, MI 48706, (517) 892-1501. **Approved for:** 13 hours of Category I Credit.

Date: March 23, Advances in Medicine. Location: Troy Hilton. **Sponsor:** Department of Medicine, Wayne State University and Philippine Medical Association of Michigan. **Cost:** $100.00 **Contact:** E. Jason Caoili 557-5660 or M. P. Reyes 494-7104. **Approved for:** 10 hours of Category I Credit.

Date: March 24, Urgent and Emergent Medicine. Location: Holiday Inn, Mt. Pleasant. **Sponsor:** Central Michigan Community Hospital. **For:** General Practitioners. **Cost:** $48.00 for physicians, $15.00 for other professional staff. **Contact:** Frank D. Johnson, MD, (517) 772-4846. **Approved for:** 7 hours of Category I Credit.

Date: March 25-29, Family Practice, 1985 - New Approaches to Common Problems in Primary Care. Location: The Towsley Center, The University of Michigan, Ann Arbor. **Sponsor:** Office of CME of the University of Michigan Medical School. **Contact:** Dove Margenau, The Office of CME, The Towsley Center, Box 057, The University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 36 hours of Category I Credit.

Date: March 28, Practical Approach to the Diagnosis and Treatment of Diabetes Mellitus and Related Problems. Location: Fetzer Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center and the Michigan Affiliate of the American Diabetes Association. **Cost:** $40.00. **Contact:** Charles L. Zeller, Jr., MD, Director of Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 5 hours of Category I Credit.

Date: April 10, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: April 18, Pulmonary Rehabilitatio Synopsis. Location: Sheraton Inr Kalamazoo. **Sponsor:** Borgess Medica Center and Southwestern Michigan Are Health Education Center. **Cost:** Physician $65.00, Others - $45.00. **Contact:** Kerr Elder, Borgess Medical Center, 1521 Gu Road, Kalamazoo 49001. **Approved fo** 5.5 hours of Category I Credit.

Date: April 24, Current Neurology - Cli ical Neurology at the Bedside. Locatio Borgess Medical Center. **Sponsor** Borgess Medical Center & Southweste Michigan Area Health Education Center. Cost: $85.00. **Contact:** William Daar Borgess Medical Center, 1521 Gull Roa Kalamazoo 49001. **Approved for:** 6 hou of Category I Credit.

Date: April 24, Diabetes Managemen Location: Henry Ford Hospital, Detro **Contact:** Henry Ford Hospital, Continuir Medical Education, 2799 W. Grand Blv Detroit 48202, (313) 876-3073. **A proved for:** 6.5 hours of Category I Cred

Date: April 25-26, 14th Annual Wayn State University Critical Care Sym posium. Location: Northfield Hilton, Tro **Sponsors:** Wayne State University, De partment of Surgery, Michigan Commi tee on Trauma, and Michigan Society Critical Care Medicine. **Contact:** Theres Sokol, Wayne State University, Depar ment of Surgery, 6-C UHC, 4201 St. Ar toine, Detroit 48201 (313) 557-500 **Approved for:** 12 hours of Category Credit.

Date: April 25-27, ACLS - Advanced Ca diac Life Support. Location: Genvieve & Donald S. Gilmore Center for Heal Education, Kalamazoo. **Sponsors:** Bro son Hospital Life Support Office & Sout western Michigan Area Health Educati Center. **Cost:** $250.00. **Contact:** Cyn Kochevar Bouma, Bronson Methodi Hospital, Life Support Office, 252 Lovell, Kalamazoo 49007, (616) 38 7576. **Approved for:** 20 hours of Categ ry I Credit.

Date: April 25-27, Hospice Dynami and Realities. Location: Sheraton-Sout field Hotel, Southfield. **Sponso** Georgetown University, Hospice Southeastern Michigan and Michig Hospice Organization. **Contact:** Comm nity Relations, Hospice of Southeaste Michigan, 22401 Foster Winter Dr., Sout field 48075. **Approved for:** 6 hours Category I Credit.

Date: April 26, Carcinoma of the Lun An Integrated Approach. Locatio Henry Ford Hospital. **Sponsor:** Hen Ford Hospital. **Cost:** $100.00 Practici Physicians, $50.00 Residents & othe

ontact: Henry Ford Hospital, Continuing edical Education, 2799 W. Grand Blvd., etroit 48202, (313) 876-3073. **Ap- roved for:** 7.25 hours of Category I edit.

te: May 2-3, American College of Sur- eons. Location: Henry Ford Hospital, etroit. **Sponsor:** Henry Ford Hospital. **ontact:** Henry Ford Hospital, Continuing edical Education, 2799 W. Grand Blvd., etroit 48202, (313) 876-3073. **Ap- oved for:** 13 hours of Category I Credit.

te: May 3, 19th Annual Cardiac Re- bilitation & Exercise Testing Confer- ce. Location: Martin Verzi Auditorium - rgess Medical Center, Kalamazoo. **onsor:** Southwestern Michigan Area alth Education Center and Institute for rdiovascular Health and Rehabilitation. **st:** Physicians, nurses, exercise person- l - $75.00, Students - $35.00. **Contact:** f Morgan, Institute for Cardiovascular alth and Rehabilitation, Borgess Medi- l Center, 1521 Gull Road, Kalamazoo 001, (616) 383-8342. **Approved for:** hours of Category I Credit.

te: May 6-8, Hemodynamic Monitor- g VIII. Location: Towsley Center, Ann bor. **Sponsor:** University of Michigan edical Center. **Contact:** Office of Con- uing Medical Education, Towsley Cen- , Box 057, University of Michigan, Ann bor 48109 (313) 763-1400. **Approved :** 14.5 hours of Category I Credit.

te: May 8, Pancreatitis. Location: St. hn Hospital. **Sponsor:** CME Committee St. John Hospital. **For:** Interested physi- ns. **Cost:** $90.00. **Contact:** Judy Dan- rt, Program Coordinator, St. John Hos- al, 22101 Moross Road, Detroit 48236 3) 343-3877. **Approved for:** 8 hours Category I Credit.

te: May 9-10, Aspiration Needle psy. Location: Henry Ford Hospital. **onsor:** Henry Ford Hospital. **Contact:** nry Ford Hospital, Continuing Medical ucation, 2799 W. Grand Blvd., Detroit 202 (313) 876-3073. **Approved for:** hours of Category I Credit.

te: May 17-18, Neurological Update. cation: Henry Ford Hospital, Detroit. **ntact:** Henry Ford Hospital, Continuing edical Education, 2799 W. Grand Blvd., troit 48202, (313) 876-3073. **Ap- oved for:** 13 hours of Category I Credit.

te: May 20, A Tangled Web: Consider- on of Brain Death. Location: Henry rd Hospital, Detroit. **Contact:** Henry rd Hospital, Continuing Medical Educa- n, 2799 W. Grand Blvd., Detroit 48202, 3) 876-3073. **Approved for:** 6.5 hours Category I Credit.

te: May 30-31, Surgical Endoscopy. cation: The Towsley Center. **Sponsor:** e University of Michigan, Office of Con- uing Medical Education. **Cost:** $295.00 ysician fee, $195.00 for others. **Con- t:** Dove Margenau, The Office of Con- uing Medical Education, The Towsley nter, Box 057, The University of Michi- n Medical School, Ann Arbor 48109- 10. **Approved for:** 13 hours of Catego- Credit.

Date: June 5, 4th Annual Michigan Oral Cleft Conference. Location: Hilton Hotel, Grand Rapids. **Sponsor:** Michigan Cleft Palate Association and Southwestern Michigan Area Health Education Center. **Contact:** Janet S. Wilson, Center for Human Services, Western Michigan University, Kalamazoo 49008. **Approved for:** 5.5 hours of Category I Credit.

Date: June 14-15, Current Topics in Ophthalmology and Symposium on Glaucoma. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 13 hours of Category I Credit.

Date: June 20-22, 35th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Resort. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

Date: July 25-26, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684, (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295.00 **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 20 hours of Category I Credit.

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DEATHS

John Berghorst, MD
Battle Creek
John Berghorst, MD, 80, a retired Veterans Administration psychiatrist, died December 3. He graduated in 1934 from the University of Michigan Medical School where he received the Alpha Omega Alpha honor society award. Doctor Berghorst served on the staffs of the state hospital in Traverse City, the state children's clinic in Lansing, and Battle Creek VA Medical Center.

Norman E. Clark, MD
Beverly Hills, California
Norman Clark, MD, formerly of Mt. Pleasant, died December 4. He was 92. Doctor Clark graduated from the University of Michigan's Medical School in 1921. He established a cardiology practice in Oak Park and was affiliated with Detroit's Providence Hospital. His generous donations led to the Founding of Central Michigan University's Historical Library and Children's Library which bear his name. Clark also was known nationally for his medical research in developing new treatments for heart disease and rheumatic fever.

Aram A. Ignatius, MD
Ferndale
Aram A. Ignatius, MD, died January 11 at the age of 76. Doctor Ignatius graduated from Wayne State University Medical School in 1937. He owned and operated a medical clinic in Ferndale for many years.

Elwood A. Jenkins, MD
Ft. Pierce, Florida
Elwood A. Jenkins, MD, died December 7 at the age of 77. Doctor Jenkins was chief of urology at Detroit Memorial Hospital from 1950-1975. He graduated from Wayne State Medical School in 1936 and later served in the US Naval Reserve as Lt. Commander at Pearl Harbor in World War II. He also served as past president of the East side Medical Society.

Maurice C. Loree, MD
East Lansing
Maurice C. Loree, MD, died December 14 at the age of 92. Doctor Loree graduated from the University of Michigan Medical School in 1917. He specialized in ophthalmology and was affiliated with Sparrow, St. Lawrence, and Ingham County Chest hospitals in Lansing. Doctor Loree also served as a Captain in World War I.

Kenneth C. MacPherson, MD
Detroit
Kenneth C. MacPherson, MD, died December 23. He was 90. Doctor MacPherson was former chief of pediatrics at Grace Hospital and Childrens Hospital in Detroit. He graduated in 1920 and served as First Lieutenant in the medical reserve in World War I.

Elwin W. Midgley, MD
Mt. Clemens
Elwin W. Midgley, MD, died November 29 at the age of 63. Doctor Midgley was an orthopaedic surgeon affiliated with South Macomb and Detroit Memorial hospitals. He graduated from the University of Rochester Medical School in 1946 and served in the US Air Force for 14 years.

Roy A. Morter, MD
Kalamazoo
Roy A. Morter, MD, died at the age of 95 on January 2. Doctor Morter graduated from the University of Oklahoma Medical School in 1913. He served as medical supervisor at a psychiatric hospital in Purcell, Oklahoma before affiliating with Borgess Hospital in Kalamazoo. He was past-president of many service clubs in Kalamazoo and served as First Lieutenant in WW II.

Tom B. Thompson, MD
Jackson
Tom B. Thompson, MD, died December 8. He was 66. Doctor Thompson graduated from the University of Cincinnati Medical School in 1942. He instituted the first heart information center in Jackson, and established a polio immunization program there in 1965. He served in the US Navy for two years and was affiliated with Mercy Hospital and W. A. Foote Hospital in Jackson.

Samuel H. Rutledge, MD
East Lansing
Samuel H. Rutledge, MD, died January 3 at the age of 73. Docto Rutledge graduated from Northwestern University Medical School in 1939. He served in the US Army from 1942-1945 with George Patton in the Big Red 1 invasion at Normandy. He also was a former chief of surgery at Sparrow Hospital in Lansing.

Elmer F. Wahby, MD
Grand Rapids
Elmer F. Wahby, MD died at the age of 60 on December 15. Doctor Wahby was chief of radiology at Butterworth Hospital for 31 years and was responsible for introducing cobalt therapy to west Michigan. He attended medical school at Western Ontario University in London. He also served as a clinical professo at Michigan State University's College of Human Medicine.

Merle E. Wehner, MD
Manistique
Merle E. Wehner, MD, died November 24. He was 70. Docto Wehner graduated from Loma Linda University Medical School in Los Angeles in 1944. He served as an army medical docto in Europe during World War I, an later as associate professor at th University of Michigan. Doctor Wehner was affiliated with Schoolcraft Memorial Hospital i Manistique.

Garrett E. Winter, MD
Walnut Creek, Colorado
Garrett E. Winter, MD, died December 17. He was 78. Doctor Winter graduated from the University of Michigan Medical School in 1932 and practiced in Grand Rapids for 40 years. He was affiliated with Butterworth, Blodgett Memorial, and St. Mary's hospitals in Grand Rapids.

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MICHIGAN: EMERGENCY CONSULTANTS INC., currently staff Emergency Departments throughout the States. Full-time and part-time positions available in rural and urban locations Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc. One Windemere Place, Petoskey 49770; 1-800 253-7092 or in Michigan 1-800-632-9650.

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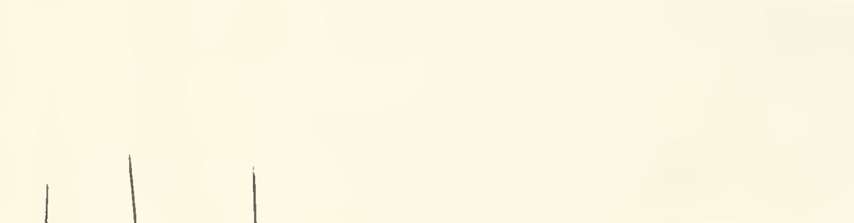

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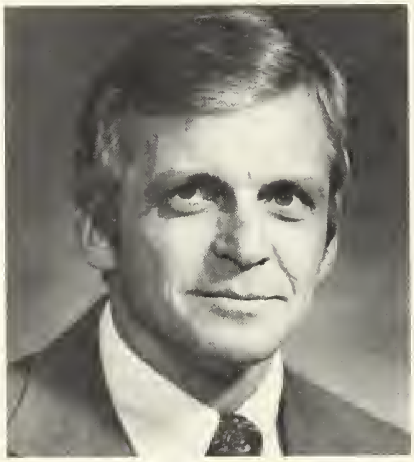
By Thomas Berglund, M

What do you mean you're not represented in the AMA?



Doctor Berglund

Over the years, one of the excuses physicians have given for not belonging to the American Medical Association is "they don't represent me." But nothing could be further from the truth, especially for Michigan physicians.

For the past nine years, John J. Coury, Jr., MD has been a member of the AMA Board of Trustees and has served as Board chairman for the past two years. This June he will in all probability be President-elect. All of us who know and admire John remember that he is a *practicing* general surgeon from Port Huron who has served as chairman of the MSMS Board of Directors and as president. Michigan has been *well represented* at the highest AMA level.

Several other Michigan physicians serve the AMA in prominent councils. MSMS Past President Donald K. Crandall, MD of Muskegon is on the Council on Medical Services; E. James Potchen, MD, MSU radiologist, is on the Council on Medical Education; Wayne County President Frank Walker, MD, serves on the Council on Long Range Planning and MSMS President Louis R. Zako, MD is on the Council on Legislation.

Michigan physicians represent various specialty societies as delegates or alternates to the AMA: James J. Humes, MD, pathology; Kenneth Krabbenhoft, MD, radiology; Clarence Livingood, MD, dermatology and Chris Zarafonetis, MD, federal and military medicine. Eli Brown, MD is representative to the Anesthesiology Section; Thomas A. Fox, MD to the Colon and Rectal Surgery Council; Henry Domzalski, MD, is Secretary to the Governing Council, Hospital Medical Staff Section; and Douglas Haddock, MD is representative to Family and General Practice Sections. Michigan physicians are *well represented* in Specialty Section Councils of the AMA.

Other active Michigan physicians serving in various AMA roles include Busharat Ahmad, MD, Committee of Foreign Medical Graduates; Billy Ben Baumann, MD, Committee on Allied Health Education and Accreditation; Julian Hoff, MD, Alternate Delegat to the Commission to Emergenc Medical Services, and John Rupke, MD, Delegate to the Commission on EMS. Serving o various Residency Review Committees are Roy Gerard, MD; B. Ken Gray, MD; Thomas Kirschbaum, MD; Charles Kraus MD; Paul R. Lichter, MD; Kenne P. Matthews, MD; Norman Nigr MD; Robert Pool, Jr., MD; Edwa Powsner, MD; Frank N. Ritter, M Herbert Sloan, MD, and Jeremi Turcotte, MD. Again, Michigan physicians are *well representec*

The official representatives le by Michigan Delegation Chairm Richard J. McMurray, MD, of MSMS to the AMA are eleven delegates and eleven alternate who work tirelessly and long t formulate the policies of the AMA. These men and women give up at least two weeks a ye to represent Michigan physicians.

Presently I am serving my seventh year on the American Medical Association Political A tion Committee Board (AMPA and am currently chairman, so Michigan Physicians are *well re resented* politically also. So, th excuse that you are not a men ber of the AMA because you a not represented is not valid. I urge those of you who used th excuse to save $330 to send yo check today to MSMS, as well as $50 for MDPAC dues.☐

Doctor Berglund, Portage, is chairman, MSMS Board of Directors. He writes this month at the invitation of MSMS President Louis R. Zako, MD.

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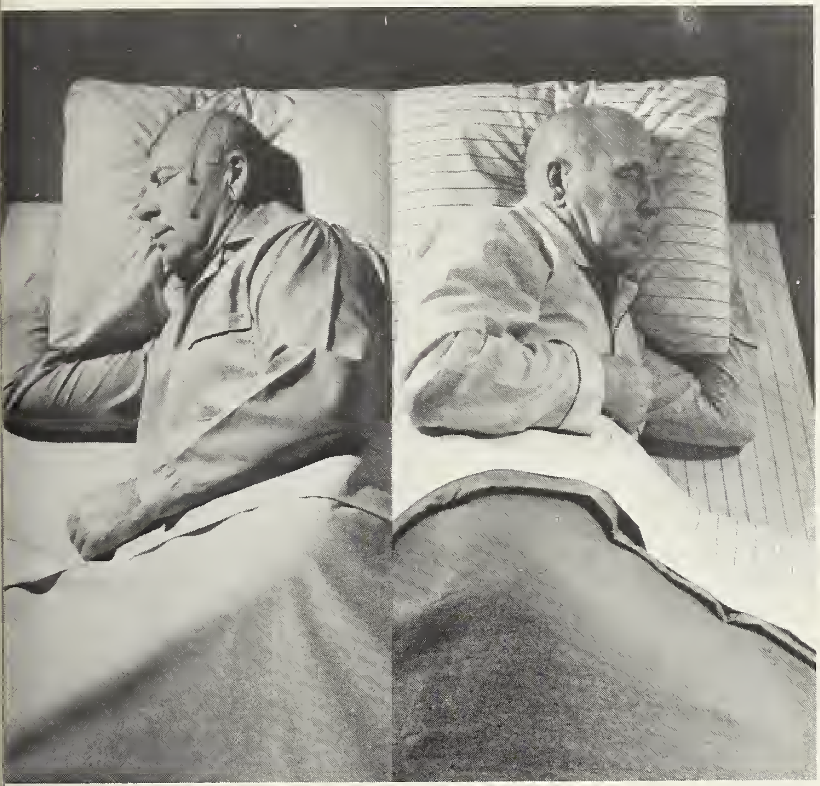

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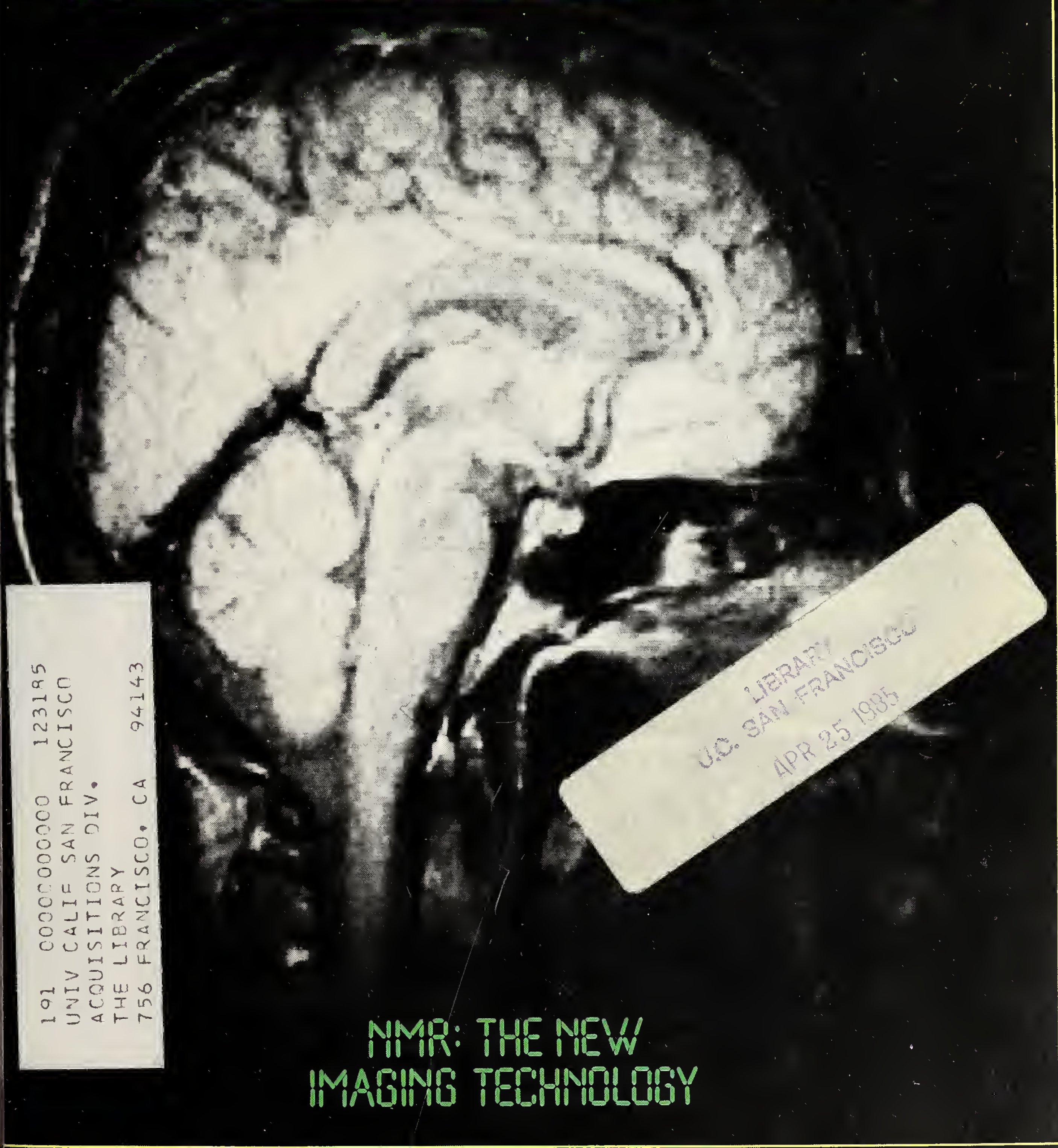
MICHIGAN MEDICINE

APRIL 1985 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 84, No. 4



NMR: THE NEW IMAGING TECHNOLOGY

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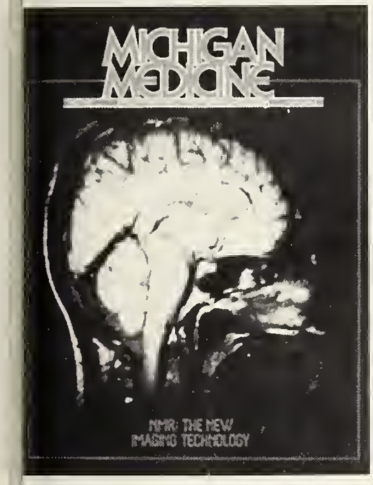
MICHIGAN MEDICINE



About the cover: The spin-echo image shown was taken on a 0.5 Tesla (field strength) research prototype nuclear magnetic resonance imager in March, 1984 at Siemens Corporate Headquarters in Erlangen, West Germany. Special thanks to James E. Seibert, subject of the image and chief engineer, and David A. Gift, specialist, both of the Michigan State University Department of Radiology, MSU College of Human Medicine and College of Osteopathic Medicine.

In next month's issue of *Michigan Medicine:* Arbitration, one of the avenues MSMS leaders are pursuing to ameliorate the malpractice situation, will be discussed in our May Special Report.

Special report

202 The new body-imaging machines, particularly nuclear magnetic resonance (NMR) units, truly are new in Michigan. NMR technology is so new, in fact, that neither the Michigan College of Nuclear Medicine Physicians nor the Michigan Radiological Society has an official position on its use. But, it is evident that hospitals and physicians believe that NMR has great diagnostic and cost-savings potential. This month's Special Report examines the cost-effectiveness and proper use of NMR; the challenges this technology poses to planners and physicians; the American Hospital Association's report on financial aspects; the American College of Radiology's NMR policy statement; Michigan's certificate of need policies and applications to date; and the just adopted statewide review standards for new health care technologies; David A. Gift; Judy Marr; American College of Radiologists; American Hospital Association; Michigan Department of Public Health.

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By Fred W. Bryant, MD

New MSMS bioethics library gathers, disseminates information

Bioethics, with its broad roots, "bio" for life and "ethics," concern for conduct, has probably always been with us, but within the past decade has grown prominent in national health circles and is now an official concern of the Michigan State Medical Society.

MSMS is accumulating a library on the subject and wants you to be aware of its objective to collect and disseminate this information. To this end, a "Bioethics Bibliography" will appear in *Michigan Medicine* from time to time. If a title catches your interest, you can obtain an individual copy by contacting the Department of Communication, Michigan State Medical Society, PO Box 950, East Lansing, Michigan 48823. Conversely, if you encounter articles we should know about, send them to Sherry Wellman at the same address.

Articles currently available for review include:

- "Do Patients Want to Participate in Medical Decision Making?"
- "Do Not Resuscitate Orders"
- "Changing Way of Death: Some Agonizing Choices"
- "MSU researchers making progress on fetal gene test"
- "Sounding Board: Law's Influence on Medicine and Medical Ethics"
- "Court issues broad right-to-die guidelines"

In addition, we're trying to develop wisdom to help regional groups forming their own Bioethics Committees. If you're in the process — or even considering such a move — share your experience with us.

Doctor Bryant is chairman, MSMS Bioethics Committee

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editoria board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or featur published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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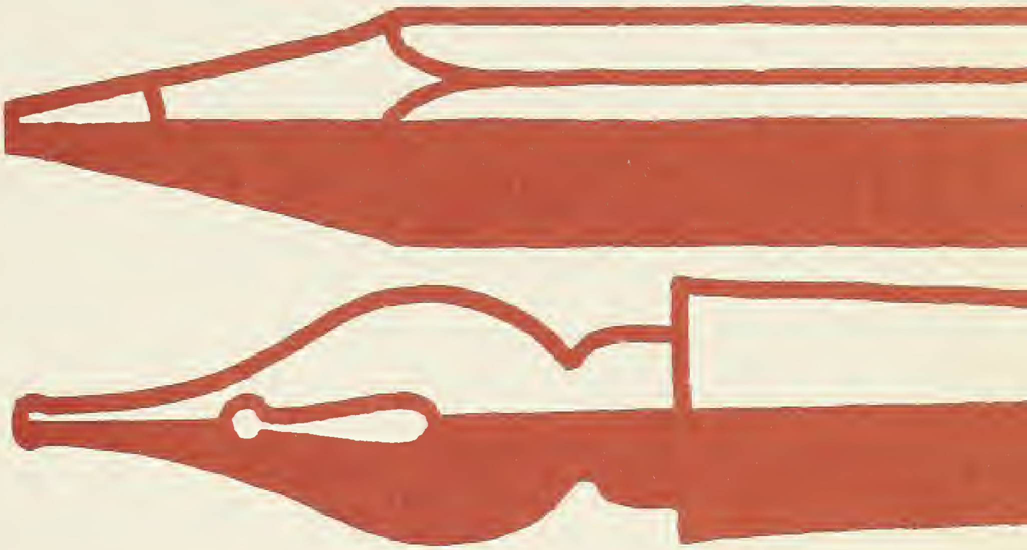


t. Paul Farm Marine sureds take note

e following letter, mailed in bruary to Ned Hughes, ad- nistrator at Gerber Memorial spital in Fremont, is pub- hed here to inform the nearly Michigan hospitals which are sured with the St. Paul Farm arine Insurance Company. ctor Robert E. Paxton, District Director, and William E. Madi- n, Managing Director of SMS, were instrumental in lping Gerber Memorial search r another insurance policy. If rber Memorial were to stay th St. Paul, the medical staff uld have been required to aintain $500,000 limits of ofessional liability insurance the hospital's insurance pre- ium would have risen by 20 rcent.

The Michigan State Medical ciety and it's 11,000 members e concerned with the recent ac- n by the Gerber Memorial spital. We are referring to the quirement that all medical staff Gerber Memorial Hospital who mit patients have $500,000 ofessional liability coverage.

While MSMS recognizes that ysicians have a social obliga- n to carry professional liability surance, evidenced by the fact at we capitalized our own ofessional liability insurance mpany, we do not believe that must be mandatory. MSMS legates at their 1981 annual eeting opposed compulsory surance as a requisite for hos- al privileges. MSMS believes at medical staffs themselves ould make the decision hether to require the medical aff to have professional liability surance.

The AMA Board of Directors emphasized recently: "The AMA is of the opinion that each hospital medical staff may determine for itself whether it will require coverage at the commonly prevailing level of policy limits as a condition for hospital staff privileges. The Board believes that if the organized medical staff makes this determination, the members of the medical staff should comply with the requirement."

MSMS also is concerned that the requirement of the $500,000 coverage is excessive. The Michigan Physicians Mutual Liability Company captive company of MSMS, reports that 63 percent of their insureds carry $100,000/$300,000 or $200,000/$600,000 insurance. We believe it punitive to most of the staff that the Gerber Memorial Hospital should choose to "paint the entire medical staff with the same brush." We would hope that you would investigate the classification systems used by insurance companies throughout the nation which serve to separate the risks by categories; e.g., those systems would show $500,000 coverage excessive for a dermatologist who has an exceedingly low professional liability risk.

Furthermore, MSMS has been informed that many of the professional liability insurance companies who insure physicians are encountering reinsurance problems. This situation will become more acute since reinsurance has a large influence on excess coverage for physicians, namely the $200,000/$600,000 and $500,000 limits. Requiring this coverage when physicians cannot obtain it seems counter productive.

We understand that Gerber Memorial Hospital has been discussing the issue with its medical staff. We would further encourage each discussion and participation with the medical staff to allow for appropriate input. We would hope that through such discussion, the medical staff and the Board of Trustees could come to a mutual agreement on this important matter.

If MSMS can be of help in bringing an agreement to fruition, we would be most happy to lend our assistance.

By Judy Marr, Edit

Cost-effectiveness and proper use of NMR debated in Michigan

This is a computerized tomography (CT) scan of the brain of a patient at the University of Michigan Hospitals suspected of having multiple sclerosis. The CT scan, however, showed no abnormality.

The new body-imaging machines, particularly nuclear magnetic resonance (NMR) units, truly are new in Michigan.

According to the Michigan Department of Public Health Division of Health Facility Planning and Construction, there is only one facility — at the University of Michigan—which has such a machine in use. Twenty additional hospitals and facilities have applied for approval to install NMR units.

NMR technology is so new to Michigan that neither the Michigan College of Nuclear Medicine Physicians nor the Michigan Radiological Society has official positions on its use.

“We have not had the machines in use long enough,” said Robert S. Ormond, MD, Flint, president of the Michigan Radiological Society, “to know what the proper place of NMR is. It's difficult for our physician groups to say anything meaningful about it at this time.”

But state guidelines for NMR machines' use become effective as this issue is mailed.

Hospitals and physicians apparently believe the nuclear magnetic resonance imaging machines are worth having and using, however. Keith J. Rathbur chief, Programming Section, Division of Health Facility Planning and Construction, reported that his department can be expecte to make decisions on over 400 certificate of need applications between May, 1985 and April, 1986.

This would be a 57 percent ir crease in applications over the highest 12 month total for the years 1979 through 1982, he continued.

“The increase in certificate of need applications is primarily du to the marketing of new technological diagnostic or treatmer equipment and the requiremen for comparative/competitive reviews,” he said.

The new diagnostic aids are expensive propositions. The pur chase and installation of an NM unit costs an average of $2 million. As one of our authors, Davi Gift of the Michigan State University Department of Radiolog points out, physicians and planners need to debate the issues of cost effectiveness and prope use.

MSMS keeping up

MSMS has been keeping up with the trends and working to elp physicians learn what they eed to know to appropriately nd efficiently use these new achines.

Courses presented at the ISMS Annual Scientific Meeting ıst November included one entled, "Modern Approach to linical Diagnostic Radiology," resented by the Michigan adiological Society.

This course was designed to id primary care physicians and adiologists in the efficient use f available radiologic modalities 1 clinical problem solving. The ourse director was Robert S. Ornond, MD, director of the Deartment of Radiology at Hurley Aedical Center, Flint, and clinical rofessor at the MSU'S Departnent of Radiology.

Another Annual Scientific Aeeting course, "Nuclear Aedicine Update: 1984," was resented by the Michigan Colege of Nuclear Medicine Physiians.

This course provided the prinary physician with basic infornation on nuclear medicine proedures in three areas: nuclear ardiology, thyroid disease and nfection. Comparison to alternate modes of diagnosis were ddressed, and by the end of the course, the attendee was expected to be able to properly select the procedure of choice to answer the clinical question.

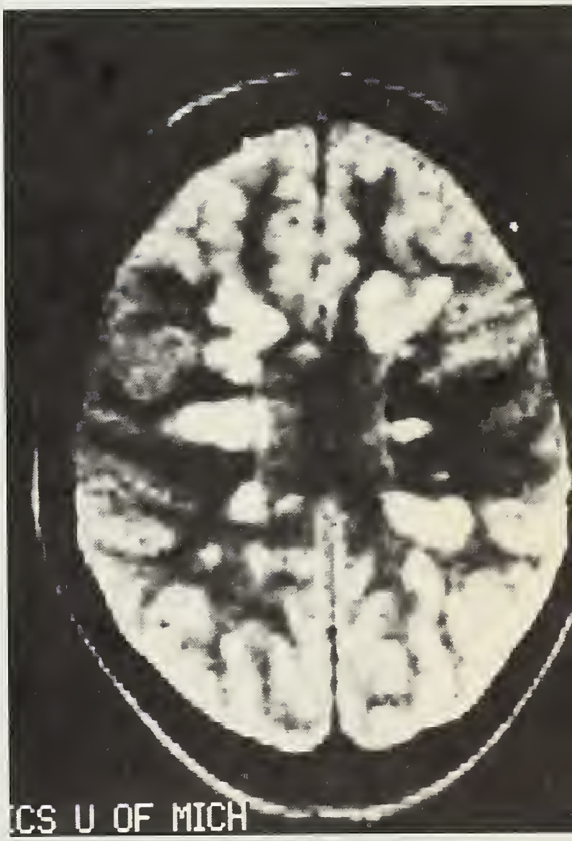
Course director was John E. Freitas, MD, Department of Nuclear Medicine, William Beaumont Hospital, Royal Oak, and clinical associate professor with the University of Michigan Medical School.

This special report is designed to bring Michigan physicians information about the placement of NMR technology in Michigan and discussion on the appropriateness of its use.

An ad hoc task force, called together by the Michigan Department of Public Health formulated the NMR use guidelines included in this special report.

In addition, we present excerpts on determining the need for NMR machines and some financial and reimbursement issues from the American Hospital Association's *NMR-Issues for 1985 and Beyond*, a guideline report published in 1983.

The MSMS Committee on Publications hopes this special report will stimulate thought and discussion in this new area, and invites your response.☐



This is a scan taken by the University of Michigan Hospitals' new magnetic resonance imager (MRI). It shows the brain of the same patient as in the accompanying photo. Unlike the CT scan, the central white areas in the MRI scan reveal lesions associated with multiple sclerosis.

By David A.

Changes and challenges in diagnostic imaging

The field of diagnostic imaging, like all of medicine, is in a tremendous state of flux. This dynamic state is being driven by the frequently competing forces of technological advancement and pressures to contain the cost of medical care. Slowly, the focus of attention is shifting from pure cost containment to the cost-effective utilization of very capable, but costly, technologies. The diversity of technologies presently available and developing in the field of diagnostic imaging presents particularly great challenges and opportunities for enhanced efficiency.

The principal technological advance in diagnostic imaging of the past decade, x-ray computed tomography, has achieved a mature technological status and now is considered to be an essential and cost-effective element of hospital and outpatient neurological services.

New technology

The present technological newcomer in diagnostic imaging is nuclear magnetic resonance. The development of this technology and an understanding of its appropriate role among diagnostic modalities is far from complete. However, NMR already has demonstrated impressive diagnostic imaging capabilities. The present challenge is to distribute this technology so that patients may have access to its demonstrated clinical capabilities, many of which are likely to be cost-effective, while at the same time placing this expensive and complex technology where optimal opportunities exist for refinement of the technology and its applications, for investigation of its relative efficacy and cost-effectiveness, and for physician training.

Looking ahead to the next five years, similar challenges may exist regarding appropriate dissemination and utilization of positron emission computed tomography, an expensive and complex technology which continues to be an important research tool, and for which useful and potentially cost-effective clinical applications are developing.

Increasingly, diagnostic images are acquired, manipulated and archived in a digital format. In addition to enhancing the ability to process and analyze images, digitization provides capability for rapid, error-free image transmission. Digital technology eventually may allow development of the "filmless" diagnostic imaging service. In the near term, we will see digital data communications allowing development of a "teleradiology" concept, which can facilitate long-distance consultation, as well as diagnostic imaging resource-sharing by hospitals and outpatient clinics.

Financing issues

Diagnostic imaging is a capital-intensive service, and present changes and uncertainties in health care services reimbursement are altering approaches to facilities financing. A general shift is occurring away from inpatien services toward outpatient services. Diagnostic imaging cente are being established by means of financial and administrative collaboration of multiple inpatie facilities to provide high-capital cost imaging services which would not be affordable for ind vidual institutions.

While fiscal and regulatory en vironments discourage capital facilities development by hospitals, private investors are finding regulatory and tax incentives to create stand-alone diagnostic imaging services. These latter in stallations are problematic in tha they frequently fall outside the realm of community and regiona health care planning efforts and to the extent that physicians hol an equity position in the facilitie place physicians in the tenuous ethical situation of controlling th utilization of resources in which they have a pecuniary interest.

Diagnostic imaging continues to advance into an era characterized by technologies having remarkable capabilities, complexity and cost, where tremendous potential exists either to enhance or diminish the cost effectiveness of medical care. Appropriate and efficient utilization of these technological resources will require increased us of the radiologist as an active diagnostic consultant in patient management to select the most efficient diagnostic strategy fron diverse and overlapping sets of technical capabilities and limitations. It also will necessitate increased thoughtfulness on the part of health care planners and physicians regarding the appropriate balance of trade-offs involving patient access, utilization cost, training and research. ☐

Mr. Gift is a Specialist in the Department of Radiology at Michigan State University, and has faculty appointments in the colleges of Human Medicine and Osteopathic Medicine. He presently is manager of the Department's research and clinical magnetic resonance projects, and is a member of the Michigan Department of Public Health Magnetic Resonance Advisory Committee.

Here's what the American Hospital Association foresees for NMR

his summary is excerpted from *MR Issues for 1985 and eyond*, Volume 4, Numbers 3 nd 4, of the American Hospital ssociation Hospital Technol- gy Series Guideline Report.

Nuclear Magnetic resonance, (NMR) is a diag- ostic imaging modality that uses nagnetic and radio-frequency elds to image body tissue and nonitor body chemistry non-in- asively. It uses no ionizing radi- tion or contrast agents, and is nimpeded by bone. Because it so highly sensitive and safe, it becoming a replacement for ome CT as well as an array of nvasive, often risky procedures uch as myelography and an- iography.

Yet the rate of diffusion of this echnology may not be propor- ional to its clinical superiority be- ause NMR is reaching the health are marketplace at a time when he economic climate is volatile. he hospital that purchases pre- naturely without carefully weigh- ng the options, risks, and benefits ssociated with NMR could find tself in severe financial difficulties. At the same time the hospital that ails to provide access to the nodality could find itself at a considerable competitive disad- vantage, particularly if neurology, cardiology, and/or oncology ac- count for a substantial percentage of admissions. Once today's bet- er educated, better informed health care consumers and their eferring physicians truly under- stand the technology and the advantages it can offer in terms of cost avoidance and reduced patients risk and suffering, they are likely to demand NMR ser- vices and seek them elsewhere f the hospital can't provide them. Conversely, the hospital that competes in these areas and does offer NMR could enjoy a competitive edge. Because of the recent wide availability of mobile systems NMR has become an important issue for smaller hospitals as well as larger ones. These and other factors make the decisions to invest in NMR a difficult one.

Determining the need for NMR

By eliminating the need for many other exams, biopsies, and exploratory surgical procedures, NMR could eventually save health care dollars and substantially reduce risk and discomfort to the patient.

The report identifies some 40 cost saving applications, 19 of which are essentially here now and would clearly save money if employed. Based on clinical experience with only seven of the 19 currently available cost saving applications, we estimate (we believe conservately) that NMR should eliminate at least 20 percent of CT head, 7.5 percent of body, 28 percent of major vessel angiography, and 50 percent of kidney angiography. We also believe that targeting research efforts intensively in these specific areas could do much to encourage more universal reimbursement.

The AHA developed a conservative model for projecting utilization based on current clinical applications. Using this model, we forecast *1.8 million patients annually* would need scans. When followup procedures on these patients are added the total number of scans becomes *2.9 million annually.* Followup procedures were calculated by using an accepted methodology for computing followup procedures for CT. By interfacing our NMR model with the CT model, we estimated that overall NMR will replace 34 percent of CT. The greatest area of impact on CT is projected to be in the area of nervous system disease (94 percent replacement), circulatory system disease (75 percent replacement) and neoplasms (30 percent replacement).

Most people asked about the status of reimbursement believed that it is progressing steadily. Much of their optimism is based on encouraging results of surveys taken of private commercial insurance carriers who are exhibiting a growing willingness to pay. One of these surveys recently conducted by Mobile Technology Inc., showed that 71 percent of the top 30 private insurance carriers now pay for NMR services according to company policy guidelines or on a case-by-case basis. This represents an increase of 50 percent in just four months according to survey researchers.

Shifting trends

However, most Blue Cross/Blue Shield plans, and HCFA do not yet pay for NMR. If they decide to continue to refuse payment for NMR, or if they establish criteria that are highly specific, the encouraging trend could shift dramatically. Given the wide applicability of NMR technology, and the mounting pressure to contain costs, we find it likely that the reimbursement authorities will be more restrictive and/or indication-specific with respect to NMR than they were with respect to CT. Near term, this is likely to alter projected revenue streams from the NMR services.☐

Magnetic resonance policy statement of the American College of Radiology

This formal statement of ACR policy was adopted by the ACR Council on September 28, 1983. The American College of Nuclear Physicians supplied *Michigan Medicine* with its Health Planning Criteria for NMR, also, at presstime.

Magnetic resonance in medicine has emerged rapidly in the last several years. Extensive investigation of the medical applications of this new modality is under way in many centers in the world. This document has been prepared in response to numerous requests received from local, regional, and state health planning entities in the United States. These health planning agencies have been confronted either by applications for certificate of need for MR systems or are preparing for the receipt of such applications. Since MR technology is new, guidelines for judging applications for certificate of need either do not exist or are in the state of preparation. This document is intended to assist planning bodies in the development of criteria in the hope that some uniformity among the various planning groups in the United States might be achieved.

Integration of medical magnetic resonance technology into medical practice

Patients' best interests will be served by MR facilities which are integrated into departments where a broad range of diagnostic imaging techniques and expertise is available. Such integration will permit the choice of the most appropriate imaging modality to meet the needs of individual patients and avoid duplication in diagnostic imaging techniques.

The concept of levels of activity

The characteristics of applicants and their institutions will be relevant to the level for which they plan to carry out MR examinations.

It would seem logical that applicants specify the type of activity which they wish to carry out which will require different resources depending upon this activity.

Levels of MR activity might be characterized as follows: 1. investigational, 2. transitional and 3. clinical.

Health planning and medical research

It is the contention of the American College of Radiology that control of medical research does not fall within the legislative or regulatory intent in the establishment of health planning agencies. Sections that follow relative to the investigational level are intended only to describe facilities, resources, and methodology which characterize research efforts in medical magnetic resonance.

Personnel requirements

I. Investigational level minimum personnel: Radiologist, physicist

d/or engineer, technologist,
d other appropriate diagnostic
bspecialists.
Physicians engaged in MR im-
ing should have a knowledge
MR imaging methods achieved
rough training, experience, or
cumented postgraduate edu-
tion. MR has many similarities
th other imaging techniques in
gnostic radiology, but there
substantial differences in op-
ational parameters and diag-
stic criteria.
A research team for medical
agnetic resonance would in-
ude:
Radiologist: The Investigative
vel will require establishment
optimum imaging parameters
various regions of the body
d various disease processes.
addition, this level will consist
comparison and correlation of
ltiple imaging modalities with
results of MR proton imaging;
mely, CT, ultrasound, angiog-
phy, and conventional radiog-
phy. By virtue of training and
perience, a radiologist with
ckground in multiple imaging
odalities appears to be most
propriate to the imaging team
this Investigational Level.
Physicist and/or Engineer: A
edical physicist and/or engineer
S or PhD) will be required at
s level to carry out multiple
sks including system develop-
ent and optimization, tech-
logists' supervision, develop-
ent of phantoms, quality assur-
ce, etc.
Technologist: A diagnostic
diologic technologist with ex-
rtise in computed tomography
other cross-sectional imaging
ethods would appear to be the
ost appropriate type of tech-
logist in view of their knowl-
ge of anatomy and cross-sec-
nal anatomy in particular.
*Subspecialty Diagnostic
diologist*: A diagnostic
radiologist with subspecialty expertise both in organ systems (e.g. neuroradiology, bone and joint radiology, abdominal radiology, etc.) and technique-oriented subspecialists (ultra-sound, CT, nuclear medicine) should be represented on the research team. Such representation will augment the investigation, both through a broad knowledge of imaging techniques in the organ subspecialties as well as knowledge of the technical subspecialties (computed tomography, ultrasound, etc.). Time requirement for these diagnostic subspecialists will depend upon the type of protocol selected.

Appropriate Physicians in Other Clinical Specialties and Subspecialties: Close collaboration between radiologists, physicists, engineers, and clinical specialists and subspecialists will be essential during the Investigational and Transitional Levels in order to develop and meet the objectives of the various protocols.

II. Transitional level

No change in the type of personnel would occur at this level in view of the continuation of research as well as clinical applications, but the numbers of personnel could be reduced.

III. Clinical level

Diagnostic radiologist, physicist or engineer (part-time or consultant basis), and technologists.

Research experience

Since the broad range of potential clinical applications for MR imaging is not known at this time, research experience and achievements in medical research, preferably in the radiological sciences, should strengthen the applicants' ability to carry out investigations utilizing accepted research methodologies during the Investigational Level.

Research protocols

Research protocols are required by institutions with Investigational Device Exemption prior to premarket approval. These research protocols must have the approval of the Institutional Review Board.

Patient base

For the Investigational and Transitional Levels, a patient base with appropriate case mix will be required to ensure a statistically significant number of patients and controls for each protocol. Approximations of the patient base might be as follows:

1. Investigational Level: Demographic data should demonstrate an appropriate number of patients to statistically assure patient accession to meet the objectives of the protocols.
2. Transitional Level: Demographic data should demonstrate patient base to insure at least four (4) patients a day for accepted clinical application.
3. Clinical Level: Appropriate patient mix to meet a minimum of six patients per day.

Data base

The institution should maintain a complete data base for each patient examined, including technical factors which may be related to patient safety, indications for the examination, results in correlation with clinical, surgical, and/or pathological findings. The data base should be designed so that it can become a part of a national data base (such as the MR Registry of the American College of Radiology). A complete data base should be collected in order to assess results of MR for future modification of criteria.

Continued on page 208

The applicant should be willing to provide a limited data base for review by the authorizing agency. Such a data base would include patient demographics and type of disease processes studied. The applicant should be willing to provide a broader data base, including evaluation of the results of MR in a clinical context to a review panel of physicians and scientists knowledgeable in the field of medical MR.

"Approved" clinical applications

Definition: Approved clinical applications are those which have been accepted to be clinically efficacious by one or more of the following mechanisms:

1. Approved major reimbursing entities such as the Health Care Financing Administration or Blue Cross/Blue Shield.
2. A recognized panel of medical experts at the national or state leves (NIH, Institute of Medicine, or similar national organizations).
3. Recommendations of national medical professional societies.

Patient selection

1. Investigational Level: All patients on research protocols approved by the Institutional Review Board.
2. Transitional Level: At least 25 percent of the patients on research protocols; minimum of four patients per day for "approved" applications.
3. Clinical Levels: Minimum of six patients per day for "approved" applications.

Other diagnostic imaging resources

In both the Clinical and Transitional Levels, appropriate equipment should be readily available in the areas of computed tomography, ultrasound, angiography, conventional radiography, and nuclear medicine. Depending on the outcome of the Investigational and Transitional Levels, the Clinical Level may not require the broad scope of other imaging modalities which would no longer be required for comparative studies.

Facility requirements

The technology in the development of MR proton and spectroscopic systems is rapidly changing so that it is not possible to specifically define facility and site requirements. The effect of the environment on the systems and the systems on the environment will vary depending upon the system. It may be quite different for resistive magnets, high-field superconducting magnets, or for permanent magnets. However, a number of generic requirements can be made:

1. Safety of patients and others must be ensured by placement of the magnet in a location where its effect upon patients with sensitive electronic devices, such as pacemakers, will be protected. (A safety manual should be developed.)

The technology in the development of MR proton and spectroscopic systems is rapidly changing.

2. The location should be situated so as to obviate the effects of the magnetic field upon sensitive electronic devices such as EKG, EEG, computers, etc.
3. During all levels, ready access to the facility by hospital patients should be provided and in a location where appropriate emergency medical procedures are available.

Patient charges and reimbursement

I. Investigational Level

At this level, no patient charges for MR examinations will be made by the applicant institution and no reimbursement sought for capital or direct operational costs.

II. Transitional Level

No patient charges or reimbursement will be sought for patients on investigative protocols. Patient charges may be made or reimbursement sought for those patients with "approved" clinical applications.

III. Clinical Level

Patient charges may be made or reimbursement sought for "approved" clinical applications.

MR spectroscopy

In vivo, human MR spectroscopy is at the earliest level of research and development. Various strategies are being advocated to obtain spectra from nuclei other than hydrogen (phosphorous, sodium, carbon, fluorine). These include methods to localize such spectra within the human body, and techniques to perform chemical shift imaging (including hydrogen). Initial results have been encouraging and the potential of in vivo MR spectroscopy appears to be significant. A few years will be required to define the role of MR spectroscopy in medical practice.

Institutions engaging in this type of research should have a formalized commitment to a research program in spectroscopy and preferably should have had experience with MR proton imaging.

In all probability, many of these investigative efforts will be joint efforts between the commercial and medical/research communities. Much of the expertise (e.g., in engineering) will be beyond the scope of personnel available to medical institutions. However, to ensure an objective evaluation of the technology and its clinical or research relevance, personnel in the medical institutions should include a minimum research team consisting of: 1. medical physicist; 2. a biochemist with MR spectroscopy experience or a biochemist and a chemist with MR spectroscopy experience; 3. diagnostic radiologist(s) with experience with tomographic spatial localization of anatomy and disease processes; 4. a broad-based team of medical imaging specialists and sub-specialists in the areas of computed tomography, ultrasound, angiography, nuclear medicine, and conventional radiography.☐

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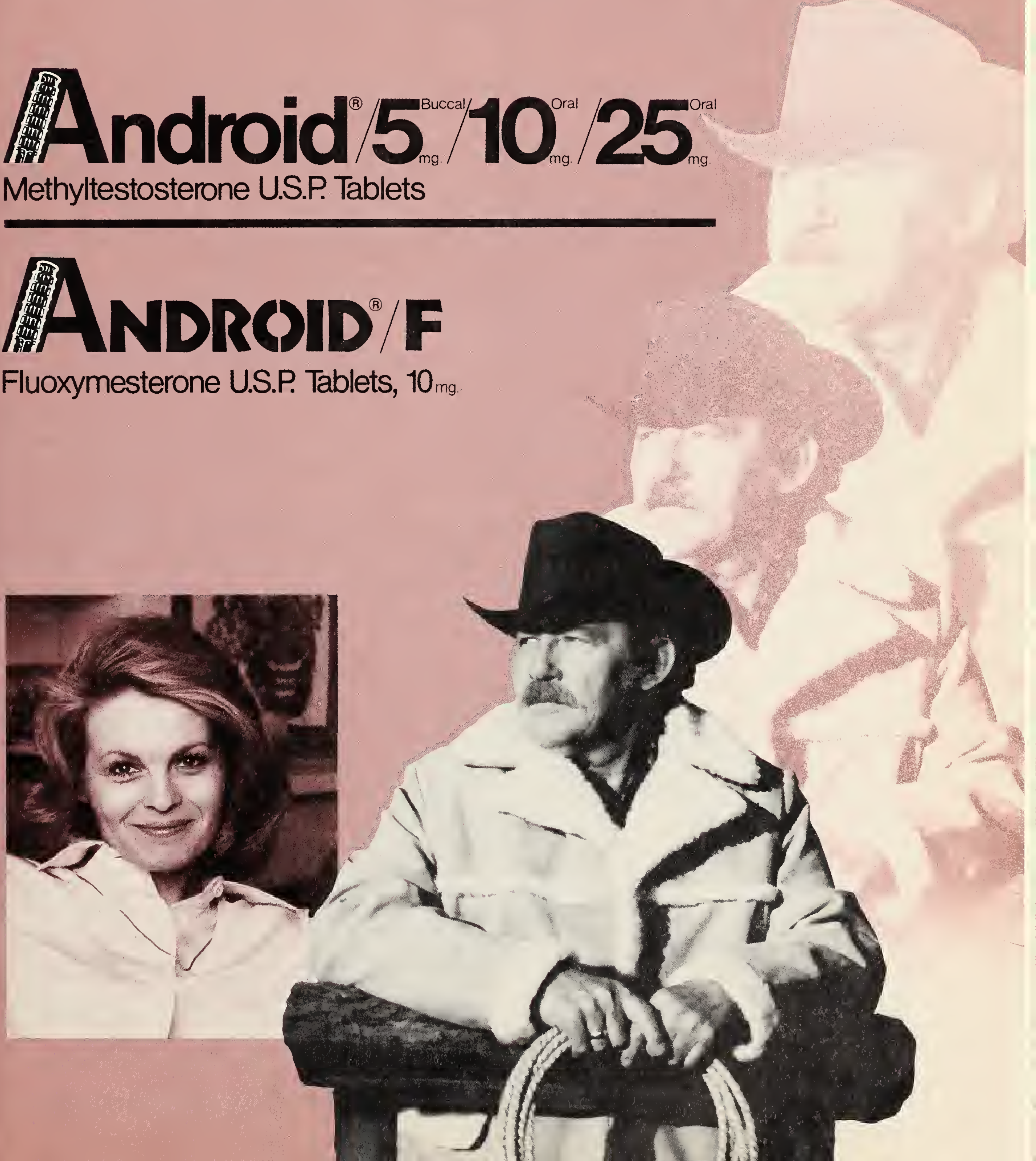

Michigan Department of Public Health issues NMR certificate of need policies

Magnetic resonance is a type of service that should be regionalized since the service involves a significant capital investment in equipment and construction and requires specialized personnel.

The Michigan Department of Public Health will use these planning policies to review applications for MR for Certificate of Need and Section 1122 review. It is the Department's intent to limit the initial placement of MR units in order to foster cost containment and to permit a "Learning and Assessment" phase— now called Phase I — for the purpose of gathering data. Based on information obtained from the data, future planning policies will be developed which will govern the placement of MR capacity for broader community use — now called Phase II. This "phased" approach has been developed to ensure the orderly placment of MR units in Michigan.

During Phase I, placement will be considered for medical schools or major tertiary care hospitals. Phase I recognizes the need to provide a balance between research and clinical applications and prudent public policy for cost containment. Planning for Phase II will begin 12 months from the date Phase I policies are adopted by the Michigan Department of Public Health. Implementation of the Phase II policies will begin after the MR committee has provided input and advice for Phase II based upon an analysis of a minimum of one (1) year of operational data from each of at least five (5) MR units or when the committee considers that it has sufficient data from Michigan and/or other states to implement Phase II.

These policies have been developed with the input and advice of an ad hoc committee representing various hospitals, universities, and planning groups in the state of Michigan. Stanley R. Smith, MD, Petoskey radiologist, represented MSMS on that committee.

Phase I guiding principles

1. Placement of a Phase I MR unit will be limited to a medical school or a major tertiary care hospital. One (1) MR unit may be approved in each HSA region with the exception of Southeastern Michigan where up to four (4) units may be approved.

2. A major tertiary care hospita must document that it provides a full range of diagnostic modalities including but not limited to radiography and fluoroscopy, computerized tomography, ul-

Continued on page 212

CON applications in Michigan to date

Nineteen facilities have contacted the Michigan Department of Public Health regarding installation of nuclear magnetic resonance imaging equipment. Of those nineteen facilities, three (Harper-Grace Hospital, Michigan State University and the University of Michigan) have received final approval from MDPH.

The University of Michigan installed NMR equipment last year, the first in the state to be placed in clinical use. Michigan State University currently is installing a General Electric 1.5 Tesla Whole Body MRI and Spectroscopy system, and expects to begin producing images May 15. Harper-Grace has joined with Wayne State University and the Michigan Cancer Society in a combined clinical imaging and research project. Groundbreaking is planned for May, and the facility will be operational a year after that.

Two more hospitals, Beaumont and Henry Ford, have completed applications and are awaiting MDPH decisions on their requests. Another hospital, Oakwood, has filed an initial CON application for NMR.

The thirteen facilities that have filed letters of intent are: Providence Hospital; Munson Medical Center; Marquette General Hospital; McLaren General Hospital; Northern Michigan Hospital; St. John Hospital; Sinai Hospital; South Macomb Hospital; Southwest Michigan Medical Enterprises; Edward W. Sparrow Hospital; Mt. Carmel & St. Joe-Pontiac Hospitals; St. Mary's Hospital; and Crittenton Hospital.

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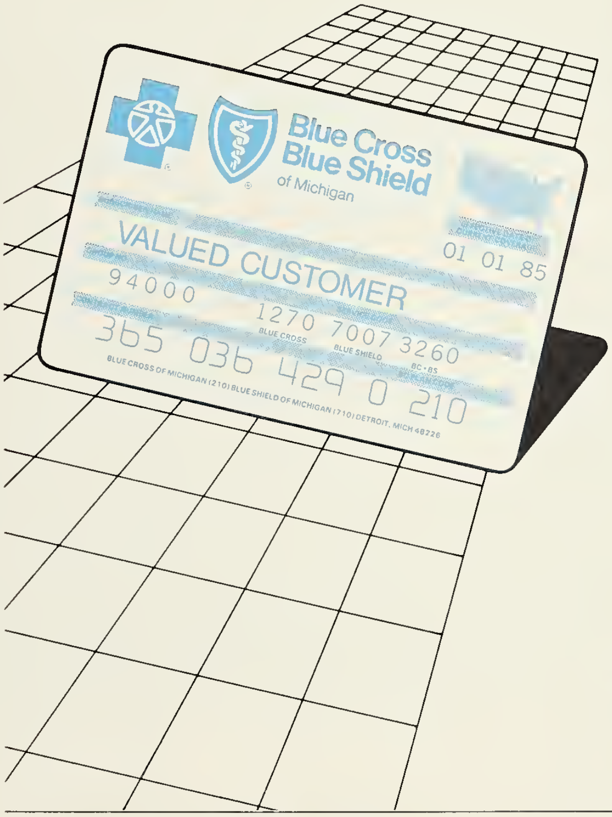
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trasound, nuclear medicine, angiography, and myelography. Further, the hospital must be able and willing to commit to providing the required data for comparison of the application of MR procedures with other existing diagnostic modalities. MR sites should have sufficient volume to maintain minimum CT scanning volume as defined by MDPH Planning Policies Pertaining to CT Scanners.

3. A major tertiary care hospital must document that it provides a full range of services including but not limited to neurosurgery, neurology, cardiology, cardiovascular surgery and a comprehensive cancer treatment program. A comprehensive cancer treatment program is defined as one in which a minimum of 300 cancer cases are treated annually and which includes at least a multi-disciplinary cancer committee, on-site megavoltage radiation therapy services, and membership in a tumor registry.

The applicant must document the number of patients undergoing diagnosis and/or treatment in these areas of specialty. Documentation shall be in the form of Professional Activity Study (PAS) or other similar report.

The applicant must document that it has on staff board certified or board eligible specialists in these areas of medical practice.

4. The applicant must document to the Department a process for accepting referrals. Referrals may be from any individual licensed to practice medicine, osteopathic medicine and surgery, dentistry or podiatry. Any policies which would limit the source of referrals would require prior approval of the Department.

The applicant must document to the Department a system which provides consistent patient information to the referring physician, dentist, or podiatrist.

5. The MR team shall consist of: a) an MR team leader; b) physicians with training and expert abilities in cross-sectional imaging, imaging modalities, and general research principles; c) physicians from various other disciplines; and d) technical support staff, i.e., physicist and/or engineer, nurse, MR technician, computer programmer, data analyst.

An MR team leader should be a board certified or eligible radiologist or other physician trained in MR who spends greater than 50 percent of his/her professional time in multiple anatomic site medical imaging or spectroscopy.

The MR team leader will have the overall responsibility for the operation of the MR unit including but not limited to the following: to insure the Certificate of Need Guiding Principles are met; oversee and direct the maintenance and communication of data to MDPH; develop and maintain utilization protocols consistent with agency by-laws; develop a quality management program consistent with agency by-laws; select and schedule medically appropriate patients.

An MR team leader should be a board certified or eligible radiologist or other physician trained in MR.

6. The applicant must outline a formal program to be offered in pre- and/or post-graduate physician training, for those operating and interpreting magnetic resonance studies or for those referring patients. Said training must include instruction on the limitations as well as relative merit of MR and appropriate formal training on principles of magnetic resonance in medicine.

The application must also outline and the applicant must have the capacity to implement a program of education and training for one or more of the following groups: technologists, medical physicists, service personnel, other hospital staff such as nurses, and the general community. An information brochure shall be provided for referring physicians as well as one for patients. After one year, the applicant shall provide recommendations for minimum training of magnetic resonance personnel as a part of the exchange of information provided for in Principle 8.

7. Each MR facility shall participate in a data collection network established and maintained by MDPH. The applicant must document that it will provide the required data in a format to be approved by and formulated together with the MDPH and other planning agencies as appropriate with input and advice from the MR ad hoc committee.

Data to be collected on each procedure will include but not be limited to patient demographics; referral information; pre-MR procedure and post-MR procedure diagnosis; volume of procedures by diagnostic category; volume of procedures by type (head, body, spine, special); what other diagnostic tests were ordered; opinion as to the ability of the modality to diagnose definitely; and analyses of patient outcomes.

Data to be collected regarding the operational aspects of an MR facility will include annual budget information (staff, supplies, utilities, etc.); cost data; and operating schedules.

8. An approved applicant must agree to participate in at least one "exchange of successful and nonsuccessful practices" per year along with other approved applicants, the ad hoc committee, and MDPH.

During any phase the Department may elect to use a nonambulatory setting or non-institutional setting in order to test alternate delivery systems. In such a case, a comparative competitive review will be conducted. Review standards for ambulatory or non-institutional settings will include items 4, 5, 7, and 8 above and 6 above as appropriate and other guidelines that may be adopted as an appendix to this plan and published in the *Michigan Register.* ☐

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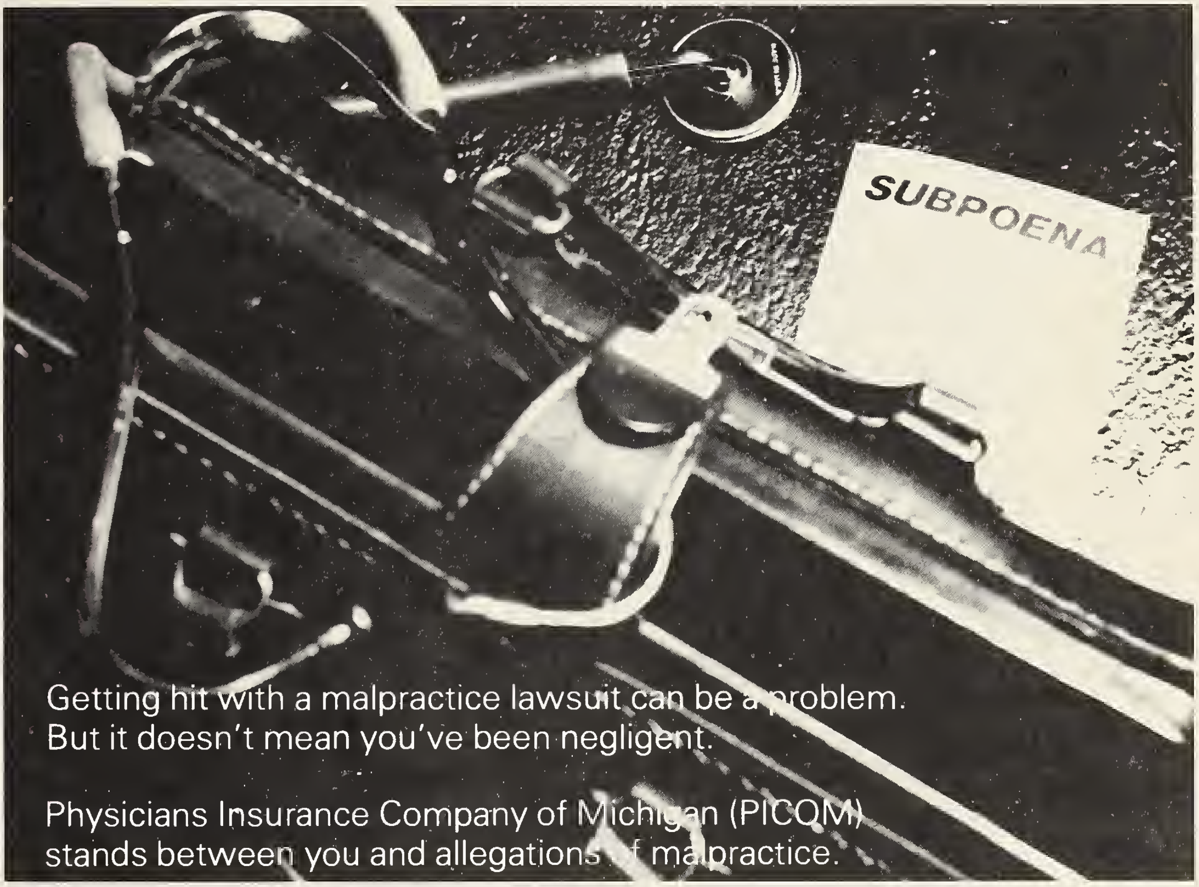

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Department of Public Health establishes review standards for new technologies

The following are MDPH procedures for the adoption of review standards for future technological diagnostic or treatment equipment or services

New health care technologies, whether for diagnostic or treatment purposes, often involve costly capital expenditures and operating costs. Health care planning has as a goal the efficient and economical delivery of health care services. Adequate standards or guidelines need to be established to determine need, efficiency, and appropriateness as required by law.

In order to define what constitues need, efficiency, and appropriateness for a new health care technology, information must be available on various aspects of the technology. However, the need to build a body of knowledge as a result of information gathering and to limit the dissemination of new technologies during the development of standards or guidelines must be balanced with the need to provide sufficient access to the service for known clinical applications.

To achieve these objectives, planning for new technologies will be accomplished in three stages. The first stage will provide for study, research, and assessment and permit data gathering based upon both research and clinical uses of the technology. The second phase involves the development of "interim" standards or guidelines. The interim standards or guidelines will be evaluated and potentially modified or replaced with long-term standards or guidelines in the third stage. The third stage involves the adoption of long-term standards or guidelines which will govern the placement of the new technology for broader community use.

An ad hoc committee selected by the department will be convened to provide input and advice during the information gathering phase, to evaluate the information gathered and to provide input and advice on subsequent standards or guidelines developed as a result of information gathering activities. The length of time required for the various stages may vary. Some new technologies may require little or no information gathering period while other technologies may require a much longer information gathering period. The length of time designated for the stages will be determined with the input and advice of the ad hoc committee.

The standards or guidelines may differentiate between research projects, demonstration projects, and projects involving the initiation of clinical services or equipment and will provide for a phased progression from research applications to general availability.

In stage one, the department will take selective use of the thre medical schools and their respective affiliated hospitals use for generic research and clinical programs; major tertiary centers with applied rials and general availability in a safe and reasone manner.

The department may include in the standards or guidelines provision for the inclusion of ambulatory or non-institutional settings in the various stages when such action is justified.

Prior to the adoption of each of the three phases in the development of new technology review standards, the department will submit the standards to the Statewide Health Coordinating Council for review. The department will issue a public notice the availability of the review star dards and the date that applicant may file notices of intent and applications for certificate of nee review. The department will dela review of all notices of intent an applications until public notice the start of the review process for each of the three phases ha been issued in the *Michigan Register.* ☐

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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By Judy Marr, Editor

One phone call got ball rolling on organ sales law

"A doctor *does* have a chance to get legislation passed," testified Detroit surgeon Robert D. Allaben, MD.

Doctor Allaben, board member of the Transplant Society of Michigan, was the initiator of SB 850, the 1984 Michigan bill to ban the sale of human organs for profit. The bill became Public Act 390 when Governor Blanchard signed it into law December 5.

"I am so impressed by what a little telephone call to MSMS can accomplish," he continued.

Doctor Allaben first became alarmed at the possibility of human organs being procured for profit when an interested person contacted the Transplantation Society of Michigan office in early 1984.

He wanted to pay people for their organs. The same thing was being proposed in Virginia at that time, where a maverick physician was trying to establish a nationwide organ brokerage.

"He claimed he could obtain more donors than we could as he was planning to pay them. He said he would pay whatever was necessary — hospital bills and funeral expenses.

"Potential recipients would pay him and that is where he would get his money. The amount batted around was $10,000.

"The general feeling of the TSM Board was that individuals shouldn't receive a transplant just because they were able to pay more than someone else," said Doctor Allaben.

"We had major ethical concerns. If someone was able to put out $10,000 and get a transplant, someone else might have to wait longer. It would make it difficult for someone on our waiting list. A competing group would cut into the number of organs we could obtain."

The Transplantation Society, founded in 1972, Doctor Allaben explained, is the parent organization for the Organ Procurement Agency of Michigan (OPAM). The TSM executive committee forms the OPAM board. OPAM has been functioning since 1979, and obtains the third largest number of kidneys for its recipients among similar agencies across the country. Currently, it has a waiting list of 450 hopeful recipients, most of whom have been waiting more than 12 months for a kidney.

Potential recipients are classified by blood type only, and each new recipient joins the list at the bottom, unless emergency conditions exist.

"OPAM is smoothly run," said Doctor Allaben. "There is no need for a competing organization. It is one of the best functioning such groups."

The person who proposed his organs-for-profit business talked about intrastate commerce.

"That's when the lights went on in my head," said Doctor Allaben. The government was proposing a federal bill banning interstate sale of organs for profit, and that's why the Michigan man proposed limiting his business to Michigan.

"I remembered that federal legislation."

MSMS gets involved

Doctor Allaben contacted Kevin Kelly, manager, MSMS Department of Government Relations, with his proposal for a bill.

Kelly and his staff organized materials provided by Doctor Allaben and researched the problem and existing related laws.

The MSMS Committee on Legislation and Regulations then took up the issue. It recommended action to the MSMS Board, which in turn urged the 1984 MSMS House of Delegates to take a stand. The delegates passed a resolution in May calling for legislation.

Kelly arranged a dinner meeting October 11 with state Sen. William Sederburg (R-Lansing), his staff and TSM officials. Sen. Sederburg agreed to sponsor a bill.

At Wayne and Oakland county medical society breakfasts with local legislators soon after, SB 850 was the subject of discussion.

Doctor Allaben and TSM member James I. Whitten, MD, Detroit, spoke in support of the bill.

"The need was immediately evident to the legislators," said Doctor Allaben. "They didn't have any problem supporting the bill."

Michael Kaplan, MD, TMS president, testified for the bill at a House Public Health Committee hearing November 28. No one testified against it.

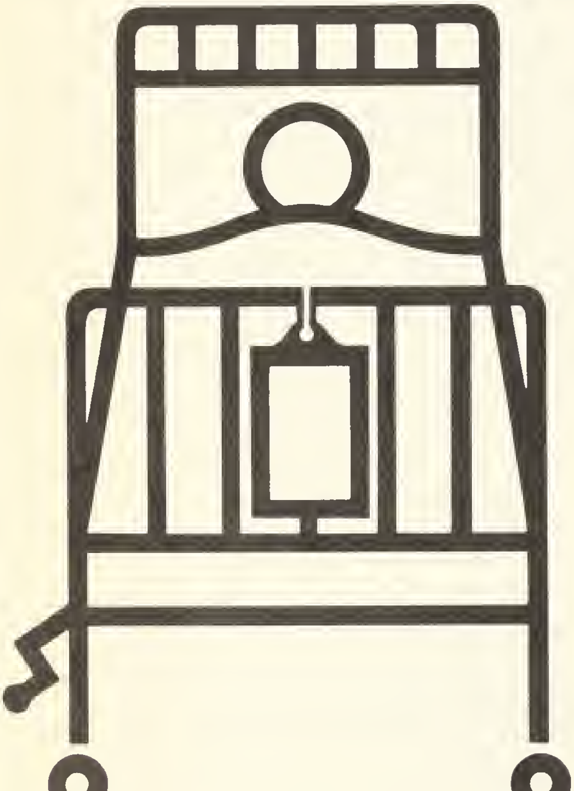
"We didn't think it would get through before the adjournment of the legislature," remembered Doctor Allaben. However, the House and Senate did move the bill through, and it was ready for the governor's signature December 5.

"It was probably a rare thing," admitted Doctor Allaben, "but it was so well orchestrated by MSMS. There is no way OPAM could have accomplished this legislation on its own. MSMS knows the ins and outs.

"It was an absolutely satisfying experience."☐

By Giovannino A. Perri, M
and Rita Biddle-Buoma, J

Medication-related hospital stays are target of new Medicaid program



The Medical Services Administration (Medicaid Program) of the Michigan Department of Social Services is implementing a new program specifically designed to reduce medication-related hospitalization(s).

In 1984, Medicaid Program expenditures totalled $1,429,844,852 with 41.1 percent attributed to inpatient hospitals. Payments to physicians were $171,277,008. Payments for prescribed drugs accounted for 6.4 percent ($91,285,755) of the 1984 budget.

In Michigan, to date, much effort has been directed at reducing hospital length of stays and avoiding admissions that are not medically necessary. To this end, the rational use of drugs can be important to reducing hospital stays. Conversely, irrational use of drugs or the wrong combination of drugs can both negate therapeutic action as well as exacerbate secondary disorders or create new disorders possibly requiring hospitalization.

A federal government study in one state estimated that $200,000 was expended for hospitalization of patients with associated inappropriate outpatient drug use patterns. Extrapolated to the statewide Medicaid population of that state, drug therapy induced hospitalization costs equalled nearly 20 percent of that state's *total* Medicaid budget.

Can there be a way for the Michigan Department of Social Services (MDSS) to alert physicians to such problems? The answer is yes. Data generated as a by-product of claims payment can also be used in Michigan by computer techniques such as th Medicaid Management Information System (MMIS) and its Surveillance and Utilization Review (S/UR) to provide comprehensiv medical history profiles.

This concept of a therapeutically oriented Drug Utilization Re view (DUR) Program using claim data as therapeutic markers was first developed by Health Information Designs (HID) Inc., in 1978 and is referred to as DUR Base™. Currently eleven states are using the DUR Base metho to improve the quality of care relative to drug therapies.

The approach of this drug utilization review program is educational in nature. Decision-making regarding patient care wi remain with the physician. It follows that the goals of Michigan' therapeutic DUR are: 1) to identify patients at "high risk" for dru therapy-induced illness which potentially could result in hospitalization; 2) to communicate this information to the physician and pharmacists involved with the patients' drug therapy regimen; and, 3) to bring about a change in the drug therapy pat-

Continued on page 22

Doctor Perri is medical consultant, and Ms. Biddle-Buoma is director, Utilization Review Division, Bureau of Health Service Review, Medicaid Services Administration, Michigan Department of Social Services.

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tern of these patients if appropriate, which, in turn, will eliminate or reduce the risk for drug-induced illness/complications.

In the experience of HID, the cornerstone of a successful drug utilization review program is not the date but the participation of local health professionals interested in improving the quality of care in their region/state. Michigan is fortunate to have many competent, dedicated professionals to assist with this effort.

To date, twelve such individuals have agreed to serve on the DUR Committee(s). They are: Brian Baran, RPh, Ingham Medical Center; Harold Bienenfeld, DO, Pontiac Osteopathic Hospital; David Dodge, RPh, Weatherwax Pharmacy; Andrew R. Ellias, DO, private practice of Internal Medicine; James Harkema, MD, MSU Clinical Center; David L. McSwain, DO, private practice of General Practice; Daniel Murphy, RPh, Chelsea Pharmacy; Robert Rosenbaum, MD, private practice of Internal Medicine; David Rovner, MD, MSU Clinical Center; Gary Stein, Pharmacy D, MSU Clinical Center; Bernard Weingart, DO, Michigan Osteo Medical Center; Timothy Wellemayer, MD, private practice of Family Practice. Mr. Frank Loll, RPh, of the Medical Services Administration will coordinate the project.

How will DUR work?

Using claims date, HID has examined the case histories of patients who are hospitalized for certain conditions to determine if there is a consistent presence of particular prescription drugs and diagnoses prior to hospitalizations. This extensive analysis has yielded 127 criteria modules of potential risk situations. The modules are grouped into six high risk disease categories and six high risk therapeutic classes of drugs. The disease categories are: cardiovascular, central nervous system, cerebrovascular, endocrine, gastrointestinal and renal. The drug categories are: antiarthritics, antidepressants, antihypertensives/diuretics, antipsychotic tranquilizers, cardiac drugs, and oral antidiabetic agents. HID will produce computer printouts using these criteria which detail the patients' drug therapies chronologically.

At this point the physicians and pharmacists will analyze the patient profiles and determine if there is a need to communicate with the physicians and pharmacists caring for these patients. If there is consensus on a case, MDSS will initiate one of a series of letters alerting the provider of a *potential* drug related problem.

HID will produce profiles on a monthly basis. The drug history profile has been designed to identify specific linkages between: patient/drug; dosage/drug; disease/drug; drug/drug.

. . . the cornerstone of a successful drug utilization review program is the participation of local health professionals. . . .

The key elements of the profiles are: 1) patient age/sex; 2) therapeutic criteria exceptions; 3) diagnosis with dates of medical service and physician identifier number (no name); 4) drugs dispensed; 5) dates of pharmaceutical service in chronological order; 6) name of drug/strength; 7) quantity dispensed/number of days supply; and 8) prescriber pharmacy identification number (no name).

Thus, the reviewers will have an ordered display of the patient's history, condition, need for drug therapy, and potential adverse effects. The reviewers must be sensitive to the order of appearance of diagnosis and initiation of a new drug therapy.

A sample case

An example may help to illustrate: A 41-year-old female heart patient with no obvious complaint of joint pain. Drugs: Lanozin, Tagamet, Inderal, Motrin. Up to this point, two physicians are seeing the patient. After four month the patient visits a third physicia and complains of abdominal pai The diagnosis is esophageal stricture. Two days later the patient is hospitalized for three weeks. The patient is discharged and continues to take the Motrin-Tagamet combination. In four more months, the patient is hospitalized a second time with a diagnosis of esophagitis.

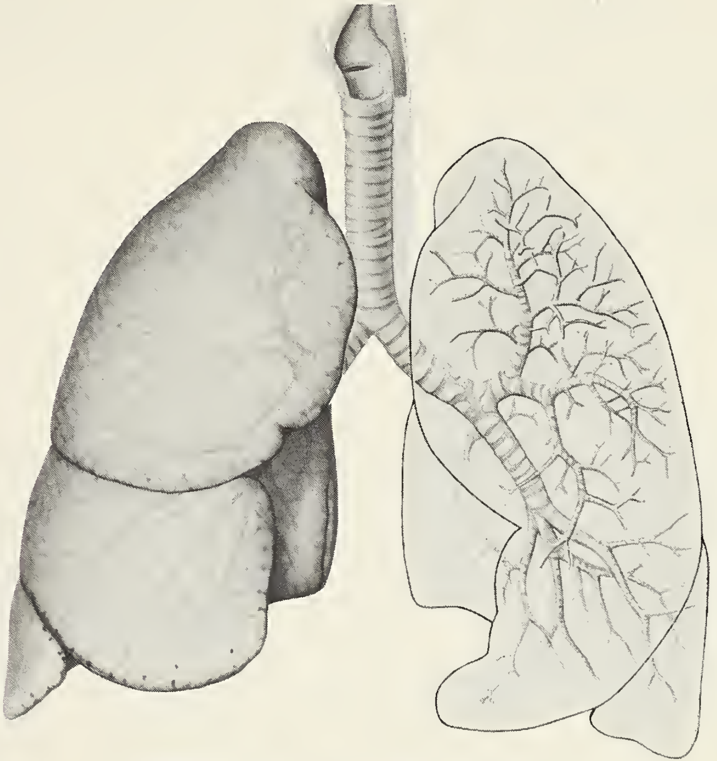
In the DUR process, a reviewe would look at the profile, identif it as a case worthy of selection. As a result, a letter would be sen to all three physicians to make them aware of the problem. The would now be aware of the dru combinations and make adjustment to the regimen. Any furthe hospitalization may now be avoided.

While the project is just gettin underway, the committee members are enthusiastic: A committee member, David Dodge, RPh, stated "If what we do has an impact on the prudent use of drugs this should really be a great program." Another committee member, Harold Bienenfeld, DO, commented, "I am very optimistic o the benefits of this program to the quality of care of Medicaid patients." David Rovner, MD, Director of the Internal Medicine Department at Michigan State University agreed that this will b a good program which will resul in improvements in the quality of care.

MDSS is likewise enthusiastic about the potential benefits to the recipients, providers and the state through this project. The Department anticipates the continued cooperation of the medical community in this new effort and stresses that this undertakin is educational and meant to be a service to the provider community.

Bernard Weingart, DO, believe that the project is innovative an creative, "It should prove to be very educational and should improve the economic situation of an already strained Medicaid budget. Super!"☐

Consider the causative organisms...



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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note. Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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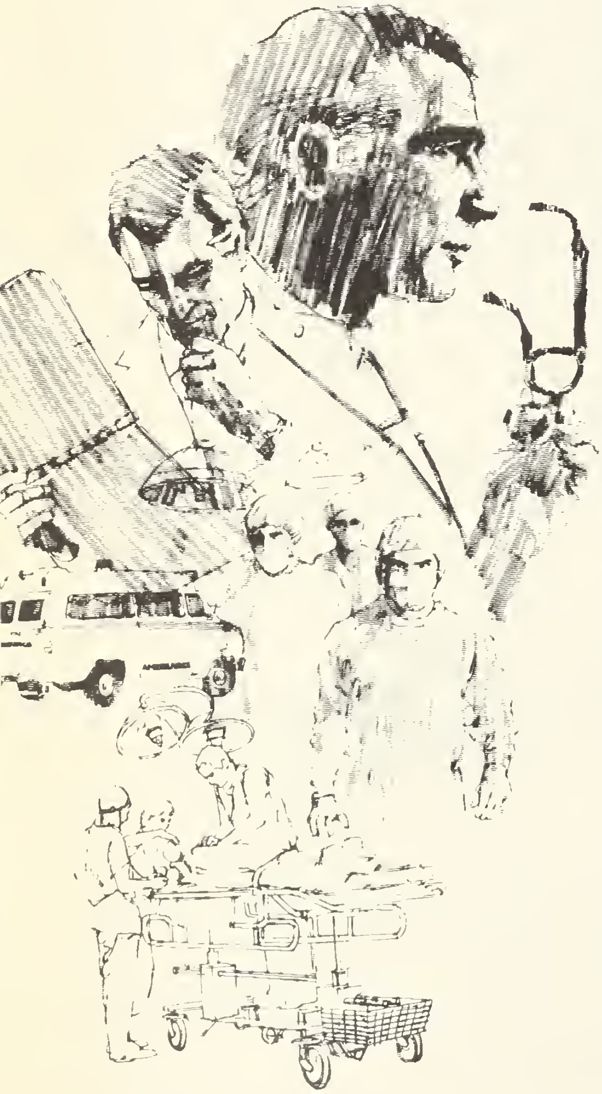
By Herbert A. Aue

Physician Placement Service brings doctors and communities together



The city of St. Johns, just north of Lansing, needs specialists in orthopedics, ophthalmology, pediatrics, otorhinolaryngology and family practice.

Hastings, south of Grand Rapids, wants physicians in the specialties of ENT, family practice, internal medicine and obstetrics-gynecology.

Manistee, along Lake Michigan, is recruiting specialists in family practice, orthopedics, internal medicine, general surgery, anesthesiology, ENT, ophthalmology, pediatrics and obstetrics-gynecology.

L'Anse/Baraga, in beautiful Upper Peninsula Copper Country, has one family physician coming and hopes for another and South Haven can offer a family physician several family practice choices.

A Muskegon group based near Mercy Hospital is interviewing family physicians.

Those openings today for physicians in Michigan are among the 251 practice opportunities registered with the Physician Placement Service of the Michigan Health Council.

The Health Council, organized in 1943 by the Michigan State Medical Society, the Michigan Hospital Association and Blue Cross and Blue Shield of Michigan, recently moved into the Stockwell Building adjacent to MSMS headquarters on Abbott Road in East Lansing. James R. Tarrant is the new MHC executiv vice president.

The Physician Placement Service, the only non-profit placement program in Michigan, is financed through registration fee and from annual grants from MSMS, BCBS/M, MHA and man hospitals, the Upjohn Company, MPMLC and PICOM.

Physician looking for their firs practice location or interested i moving to a new location are encouraged to contact the Mich gan Health Council for more details. Registration is free for resident members of MSMS, while there is a small registration fee for other doctors.

Physicians considering an associate or another group membe can, for a nominal charge, obtai biographical information about the 150-plus doctors who are available.

During its 40-year history, MHC has worked to "encourag young physicians to stay in Mich gan after medical school and residency training here," stressed Roy E. Peterson, president of th Michigan Health Council and th chief executive of the Mott Children's Health Center in Flint.

MSMS recently mailed a free-of-charge registration blank for the placement service to the growing number of its house officer members. The Michigan

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Herbert A. Auer retired January 1 as the Michigan Health Council executive vice president. He left the MSMS staff in 1979 as a deputy director and after 20 years of service.

cademy of Family Physicians ooperates in a like manner.

Although a total of 80 com-unities have registered their eeds with MHC, far more of em report openings for family hysicians than for any other pecialists. There now are 20 pportunities for pediatricians, eneral internists and obstetri-ians/gynecologists. The need for rthopedic specialists also is uite evident.

There are opportunities all cross the state in small com-unities with quality hospitals for amily physicians—St. Johns, astings, Manistee, South Haven, aline and others—as well as rger communities like Muske-on, Saginaw and Flint. Several pper Peninsula communities ffer opportunities, too.

meeting place

Often the annual MHC-spon-ored Physicians Recruitment onference serves as the "meet-ng place" for physicians looking or their first, or a new, location nd for physicians who are re-ruiting. The hospital administra-or often is the pivot for the physi-ian's or community's effort.

In 1981, for example, John S. acDonald, MD, an internist who ad graduated from Michigan tate University College of uman Medicine and from the eaumont Hospital internal edicine residency program, at-ended the conference in Lansing. aul McNamara, administrator of linton Memorial Hospital, and other members of a St. Johns recruitment team, also were there. Paul invited Doctor MacDonald to visit St. Johns. After considering several Michigan communities, Doctor MacDonald chose St. Johns and he still is practicing there.

"St. Johns was the right place for us because I personally wanted to practice in a rural community and my wife wanted an urban setting," explained Doctor MacDonald.

More than once, the MHC staff has taken residents to interested communities to participate in town meetings. The MHC executive took one young future family physician several years ago to one such meeting in a southern Michigan town. The physician considered the opportunity for some time then asked MHC about another location. The doctor and his wife were taken to a "meet a future doctor" meeting sponsored by a mid-Michigan hospital. That community did not have a church in the denomination the couple sought.

So, again MHC took the doctor and his wife to a meeting, this time sponsored by the Zeeland hospital and local chamber of commerce. An older doctor in that area wished to retire and the community worked hard to recruit the couple. As a result, Donald Beam, MD, is practicing today in the Zeeland area.

Post-military placement

Each year, some physicians completing military service register with the MHC Placement Service and thus find their practice location.

Suzanne Williams-White, MD, wrote MHC in 1982 that she wished to return to Michigan at the end of her active duty in the Navy to seek out "a group practice, either private or HMO." She is a member now of the medical staff of Health Central, a Lansing HMO.

The physicians and hospital administration on the MHC Board of Trustees point out that the active role of the MHC Placement Service helps to keep down the costs of health care in Michigan. A community can successfully recruit a new doctor through MHC at a nominal registration fee, far below the head-hunter fees of $17,000-$20,000 cited in a recent news article in *USA Today*. Ony a few of the very large medical care delivery institutions in Michigan employ a full-time physician recruiter. Detailed information about the operation of the Michigan Health Council Physician Placement Service may be obtained by writing to Michigan Health Council, Stockwell Building, 1305 Abbott Road, Suite 105, East Lansing 48823. James Tarrant, the MHC executive, will send materials and gladly visit with any physician, group, clinic, hospital staff or community looking for one or more physicians.☐

MSMS leaders discuss liability crisis with insurance commissioner

Michigan State Medical Society leaders met March 6 with Michigan Insurance Commissioner, Nancy Baerwaldt and her staff to discuss the rising cost of professional liability insurance of Michigan physicians. MSMS President Louis R. Zako, MD, is heading MSMS efforts to inform government officials, the legislature and the public of the seriousness of the liability crisis. MSMS leaders also stressed MSMS commitment to promote arbitration as an alternative to the tort system. The Michigan Arbitration System is under the direction of the Insurance Bureau.

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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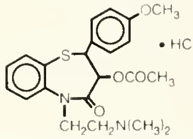
DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash asthenia (1.2%), AV block (1.1%). In addition, the followin were reported infrequently (less than 1%) with the order of p tion corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, dia, palpitations, congestive heart syncope.
Nervous System:	Paresthesia, nervousness, somn tremor, insomnia, hallucinations, and
Gastrointestinal:	Constipation, dyspepsia, diarrhea, mild elevations of alkaline phosphatas SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photose
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing epis vasospastic angina developed periods of transient asym asystole approximately five hours after receiving a singl dose of CARDIZEM.

The following postmarketing events have been report quently in patients receiving CARDIZEM: erythema multifo kopenia; and extreme elevations of alkaline phosphatase SGPT, LDH, and CPK. However, a definitive cause and effect these events and CARDIZEM therapy is yet to be establis

OVERDOSAGE OR EXAGGERATED RESPONS

Overdosage experience with oral diltiazem has been Single oral doses of 300 mg of CARDIZEM have been well by healthy volunteers. In the event of overdosage or exa response, appropriate supportive measures should be em addition to gastric lavage. The following measures may be co

Bradycardia	Administer atropine (0.60 to 1.0 mg) is no response to vagal blockade, a isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fix degree AV block should be treated diac pacing.
Cardiac Failure	Administer inotropic agents (isopr dopamine, or dobutamine) and diureti
Hypotension	Vasopressors (eg, dopamine or lev bitartrate).

Actual treatment and dosage should depend on the sever clinical situation and the judgment and experience of the physician.

The oral/LD_{50}'s in mice and rats range from 415 to 74 and from 560 to 810 mg/kg, respectively. The intravenous these species were 60 and 38 mg/kg, respectively. The or dogs is considered to be in excess of 50 mg/kg, while leth seen in monkeys at 360 mg/kg. The toxic dose in man is n but blood levels in excess of 800 ng/ml have not been as with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerot nary Artery Disease or Angina Pectoris at Rest Due nary Artery Spasm. Dosage must be adjusted to each needs. Starting with 30 mg four times daily, before meal bedtime, dosage should be increased gradually (given i doses three or four times daily) at one- to two-day inter optimum response is obtained. Although individual pati respond to any dosage level, the average optimum dosa appears to be 180 to 240 mg/day There are no available data ing dosage requirements in patients with impaired renal o function. If the drug must be used in such patients, titration carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to ab anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may coadministered with short- and long-acting nitrates, have been no controlled studies to evaluate the an effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 1 0088-1771-47) and in Unit Dose Identification Paks of 1 0088-1771-49). Each green tablet is engraved with MARIO side and 1771 engraved on the other. CARDIZEM 60-m tablets are supplied in bottles of 100 (NDC 0088-1772-47) a Dose Identification Paks of 100 (NDC 0088-1772-49). Ea tablet is engraved with MARION on one side and 1772 on

Issue

Another patient benefit product from

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LABORATORIES, INC
KANSAS CITY, MISSOURI 64137

ɔre prescribing, see complete prescribing information in SK&F CO.
ature or *PDR*. The following is a brief summary.

VARNING

his drug is not indicated for initial therapy of edema or hypertension.
dema or hypertension requires therapy titrated to the individual. If this
ombination represents the dosage so determined, its use may be
nore convenient in patient management. Treatment of hypertension
nd edema is not static, but must be reevaluated as conditions in
ach patient warrant.

traindications: Concomitant use with other potassium-sparing agents
 as spironolactone or amiloride. Further use in anuria, progressive
l or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
ssium. Hypersensitivity to either component or other sulfonamide-
ved drugs.

nings: **Do not use potassium supplements, dietary or otherwise, unless
kalemia develops or dietary intake of potassium is markedly impaired.**
pplementary potassium is needed, potassium tablets should not be
d. Hyperkalemia can occur, and has been associated with cardiac irregu-
ies. It is more likely in the severely ill, with urine volume less than
 liter/day, the elderly and diabetics with suspected or confirmed renal
fficiency. Periodically, serum K^+ levels should be determined. If hyper-
mia develops, substitute a thiazide alone, restrict K^+ intake. **Asso-
ed widened QRS complex or arrhythmia requires prompt additional
apy.** Thiazides cross the placental barrier and appear in cord blood.
 in pregnancy requires weighing anticipated benefits against possible
rds, including fetal or neonatal jaundice, thrombocytopenia, other
rse reactions seen in adults. Thiazides appear and triamterene may
ar in breast milk. If their use is essential, the patient should stop
ing. Adequate information on use in children is not available. Sensitivity
tions may occur in patients with or without a history of allergy or
chial asthma. Possible exacerbation or activation of systemic lupus
hematosus has been reported with thiazide diuretics.

cautions: The bioavailability of the hydrochlorothiazide component of
zide' is about 50% of the bioavailability of the single entity. Theoreti-
, a patient transferred from the single entities of Dyrenium (triamterene,
F CO.) and hydrochlorothiazide may show an increase in blood pressure
luid retention. Similarly, it is also possible that the lesser hydro-
rothiazide bioavailability could lead to increased serum potassium levels.
ever, extensive clinical experience with 'Dyazide' suggests that these
ditions have not been commonly observed in clinical practice. Do
odic serum electrolyte determinations (particularly important in patients
iting excessively or receiving parenteral fluids, and during concurrent
 with amphotericin B or corticosteroids or corticotropin [ACTH]).
odic BUN and serum creatinine determinations should be made,
ecially in the elderly, diabetics or those with suspected or confirmed
l insufficiency. Cumulative effects of the drug may develop in patients
 impaired renal function. Thiazides should be used with caution in
ents with impaired hepatic function. They can precipitate coma in
ents with severe liver disease. Observe regularly for possible blood
rasias, liver damage, other idiosyncratic reactions. Blood dyscrasias
 been reported in patients receiving triamterene, and leukopenia,
mbocytopenia, agranulocytosis, and aplastic and hemolytic anemia
e been reported with thiazides. Thiazides may cause manifestation of
nt diabetes mellitus. The effects of oral anticoagulants may be
eased when used concurrently with hydrochlorothiazide; dosage adjust-
nts may be necessary. Clinically insignificant reductions in arterial
ponsiveness to norepinephrine have been reported. Thiazides have also
n shown to increase the paralyzing effect of nondepolarizing muscle
ants such as tubocurarine. Triamterene is a weak folic acid antagonist.
eriodic blood studies in cirrhotics with splenomegaly. Antihypertensive
cts may be enhanced in post-sympathectomy patients. Use cautiously
urgical patients. Triamterene has been found in renal stones in asso-
ion with the other usual calculus components. Therefore, 'Dyazide'
uld be used with caution in patients with histories of stone formation.
w occurrences of acute renal failure have been reported in patients on
zide' when treated with indomethacin. Therefore, caution is advised in
inistering nonsteroidal anti-inflammatory agents with 'Dyazide'. The
wing may occur: transient elevated BUN or creatinine or both, hyper-
emia and glycosuria (diabetic insulin requirements may be altered),
ruricemia and gout, digitalis intoxication (in hypokalemia), decreasing
li reserve with possible metabolic acidosis. 'Dyazide' interferes with
rescent measurement of quinidine. Hypokalemia is uncommon with
zide', but should it develop, corrective measures should be taken such
potassium supplementation or increased dietary intake of potassium-
 foods. Corrective measures should be instituted cautiously and serum
assium levels determined. Discontinue corrective measures and
zide' should laboratory values reveal elevated serum potassium.
ride deficit may occur as well as dilutional hyponatremia. Concurrent
 with chlorpropamide may increase the risk of severe hyponatremia.
um PBI levels may decrease without signs of thyroid disturbance. Cal-
 excretion is decreased by thiazides. 'Dyazide' should be withdrawn
re conducting tests for parathyroid function.

zides may add to or potentiate the action of other antihypertensive
gs.

retics reduce renal clearance of lithium and increase the risk of lithium
icity.

erse **Reactions**: Muscle cramps, weakness, dizziness, headache, dry
th; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermat-
gical conditions; nausea and vomiting, diarrhea, constipation, other
trointestinal disturbances; postural hypotension (may be aggravated by
hol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias,
rus, pancreatitis, xanthopsia and respiratory distress including pneu-
itis and pulmonary edema, transient blurred vision, sialadenitis, and
igo have occurred with thiazides alone. Triamterene has been found in
al stones in association with other usual calculus components. Rare
idents of acute interstitial nephritis have been reported. Impotence has
n reported in a few patients on 'Dyazide', although a causal relationship
 not been established.

**plied: 'Dyazide' is supplied as a red and white capsule, in bottles of
0 capsules; Single Unit Packages (unit-dose) of 100 (intended for
titutional use only); in Patient-Pak™ unit-of-use bottles of 100.**
-DZ:L39

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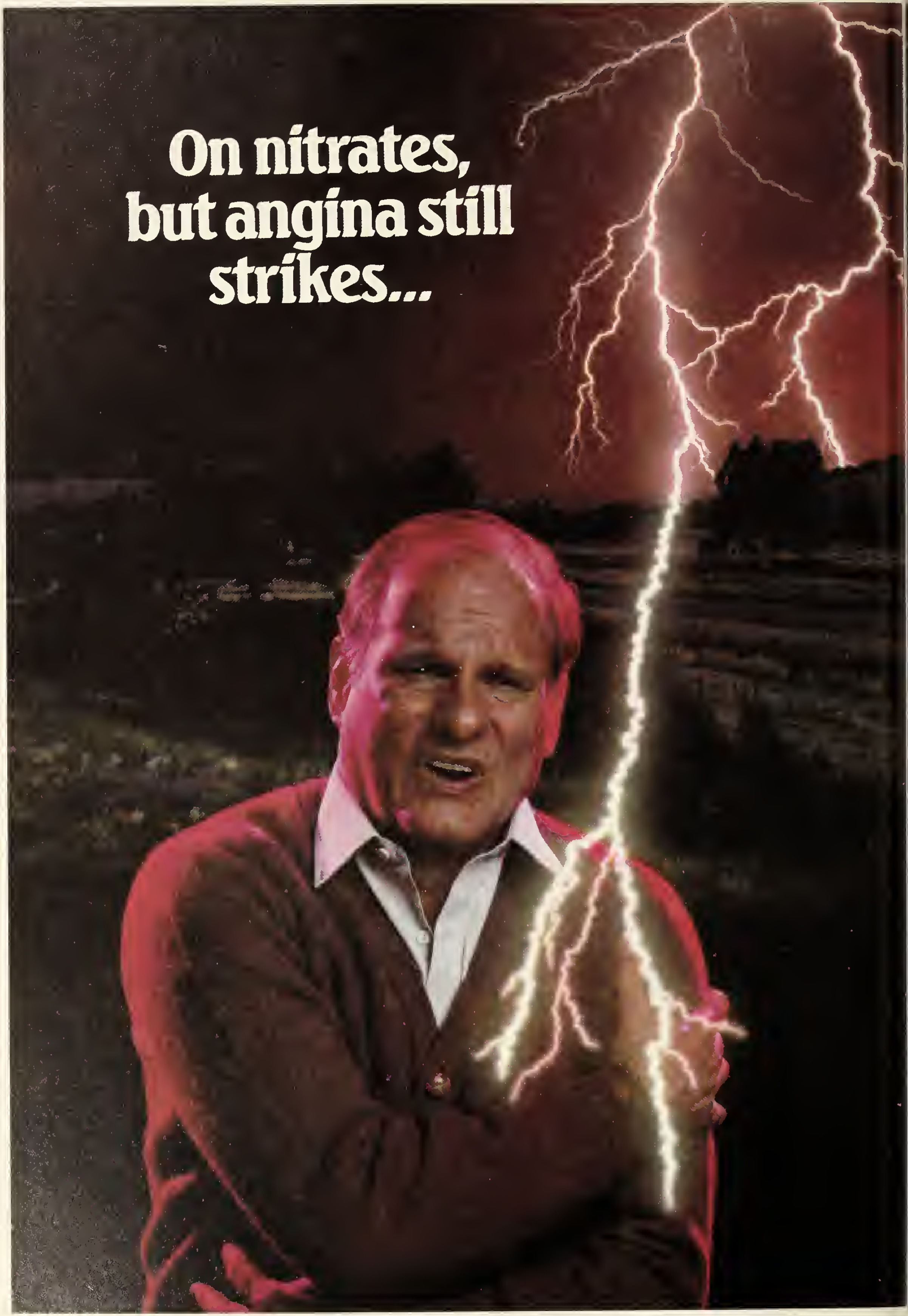
On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® **TABLETS**
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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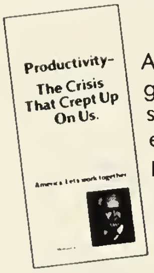

America's productivity growth rate has been slipping badly for several years now, compared to that of other nations. And it's adversely affecting each and every one of us.

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By Carole Eberl

Doctor McMurray, center, and his family posed for this photo during last year's House of Delegates meeting where he was named president-elect. His family includes, from left to right: son-in-law George Martin; daughter Gail Martin; his wife LaMoine; Doctor McMurray; son Mark; Mark's wife Laurie, and son Kirk.

MSMS president-elect Richard McMurray, MD talks about challenges ahead

The way Doctor Richard McMurray sees it, Michigan physicians have only one choice—accept and move along with changes in the health care delivery scene.

"Or we can put our heads in the sand and if we leave them there long enough, our bones will bleach right beside us," he maintains.

Doctor McMurray, the next president of the Michigan State Medical Society, said physicians are going to have to develop marketing programs to compete with the competition.

"The physician is going to have to develop his own marketing approach to survive, be it having hours from 8-10 at night, or going back to making house calls, or having group sessions—whatever is necessary for him to provide the service his patients want," he predicted.

He said the number one thing MSMS needs to do is get that message out to its members.

"Although the change may seem onerous to us now and may not be as we would perceive it should be, we should look upo these changes as an opportunit to enhance the practice of medicine," he continued.

He sees the changes as "an opportunity to revamp the healt care delivery system under the direction of people who know how it should be done, basicall the physician.

"We must accept the change that are going to be and then t to direct the changes for the benefit of our patients and for th benefit of our profession," he added.

Continued on page 23

Ms. Eberly is a Lansing-area freelance writer.

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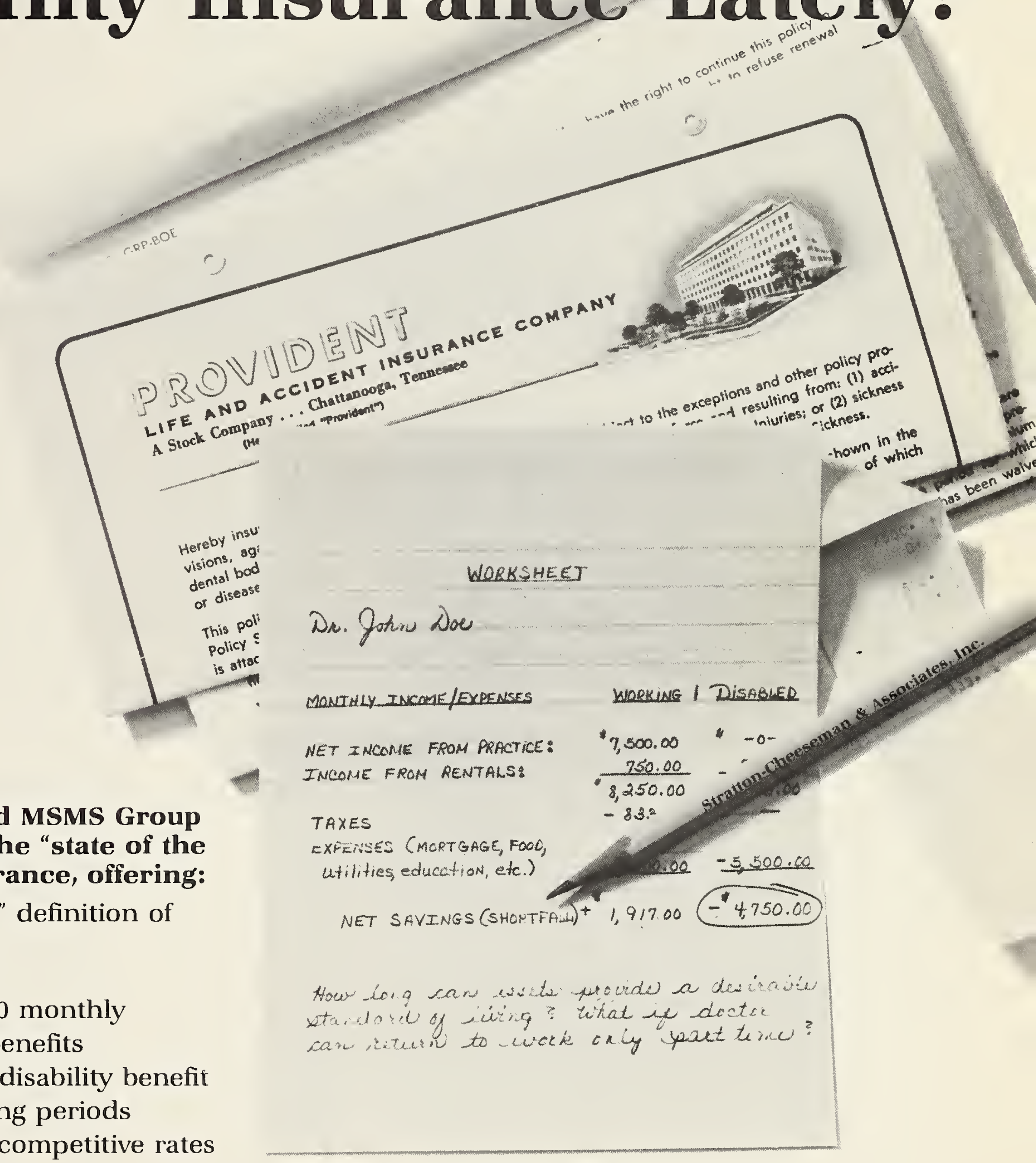
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Dr. John Doe

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Doctor McMurray addresses the 1984 House of Delegates immediately after being named MSMS president-elect.

McMURRAY/Continued

Such views seem almost radical for a physician who "in the old days" had been known to accept a thank you as payment for treatment. But for Doctor McMurray, who has been a Flint obstetrician since the 1950s, change has been a way of life. Only his comfortable office furnished with such homey touches as photos of his three children as youngsters, a print of a young girl and boy feeding chickens, an ivory-color Early American lamp, a jade plant, maple chest and a no-nonsense metal desk seems like a refuge from the changing world.

But the changes he has seen in his specialty have been good, he admits. The maternal death rate has decreased. Would-be mothers who chronically lost their babies at 4-6 months are being helped. Babies born at 24 weeks are now being saved. Deaths due to cancer of the cervix have dramatically declined.

A happy specialty

Why did he choose obstetrics as a specialty?

After a stint in family practice and pediatrics as an intern, which both disillusioned him, he went on to obstetrics "where for the first time I actually saw something happen.

"I could see things through to the finish," he said. "There was usually a happy result and everyone went away happy. There was also a certain amount of surgery connected with my specialty which I enjoy doing."

He laughs when he says some people would say a physician picks obstetrics because he or she had a domineering mother.

"I don't think so," he said. "I found it a happy specialty and one that seems to give almost immediate fulfillment."

He warned, however, if someone were looking only for financial rewards, he or she would be better off in another field.

"If someone really wants to work hard, I think medicine still is a great place," Doctor McMurray said.

In fact, at 62 he has no plans to retire.

"I remember once throwing the words out 'retirement' to my daughter and she said 'Why are you going to do that?'" he recalled. "And I said I'd like to play around. Her response was 'You're never happier than when you're working.'

"I don't ever recall getting up in the morning and thinking, 'Oh, God, I've got to go do this, do that,'" he added. "I remember thinking, 'Oh, God, is it time to get up already?'"

The malpractice problem

Although Doctor McMurray has nothing but high marks for medicine as a career, he also is a realist—and that includes his views on malpractice.

"I'm absolutely positive there aren't more doctors practicing bad medicine than there were 5 years ago," he said. "I know that a truism. I'm also sure there is more than one way to treat a patient."

Doctor McMurray plans to continue the lead of Louis Zako, M MSMS president, in working ou some solutions to the problem because "ultimately it is the patient who is paying for malpractice."

"I think every doctor has to practice the best medicine he knows how, he must be diligen in his record-keeping, he simpl must discuss things with his patient and the family, he must show them that he cares and tre them with the respect they want he said. "At the present time th is his best shot at preventing lit gation."

Although Doctor McMurray w be busy tackling these tough issues this year, he hopes to find time for his avocations of golf an skiing—two activities well-suite to Michigan weather.

"We have winter and we hav summer in Michigan," he said. "My avocations coincide with th seasons. Sometimes it is tough to do both in the same week, b I have managed it."

An accomplished skier, Docto McMurray is on the ski patrol a Boyne Highlands. The patrol offers him a change of pace from medicine, yet relies on his professional skills at times. The patr also allows him to socialize wit persons in various vocations.

Although his three children ar grown now, he said skiing had been a wonderful family sport that they all loved.

"You can take your family an be with them and yet not be o each other's back all the time," he said. "You go your way and the kids go their way. Yet, you all end up together again—hopefully."

And this summer? Well, Docto McMurray hopes not to be caught with his head in the san either professionally or on the golf course.☐

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No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

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Winthrop

Talwin® Nx

CIV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

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Winthrop-Breon

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Please see following page for Brief Summary.

Talwin® Nx ⓘⓥ

Each tablet contains pentazocine HCl, USP equivalent to 50 mg base and naloxone HCl, USP equivalent to 0 5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

TALWIN® Nx is intended for oral use only Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injectinn either alone or in combination with other substances (See **Drug Abuse and Dependence** section)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention, these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol* Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis

Precautions: *CNS Effect* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment In long-term use, precautions should be taken to avoid increases in dose by the patient *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants *Myocardial Infarction* Use with caution in patients with myocardial infarction who have nausea or vomiting *Drug Interactions Usage with Alcohol* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed *Pregnancy Category C.* Should be given to pregnant women only if clearly needed *Labor and Delivery* Use with caution in women delivering premature infants Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown *Nursing Mothers* Caution should be exercised when administered to a nursing woman *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope *Respiratory* Rarely, respiratory depression *CNS Acute CNS Manifestations* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted *Other CNS Effects* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor *Gastrointestinal* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress *Allergic* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora *Ophthalmic* Visual blurring and focusing difficulty *Hematologic* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia *Other* Headache, chills, insomnia, weakness, urinary retention

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance

Dependence and withdrawal symptoms have been reported with orally administered pentazocine Patients with a history of drug dependence should be under close supervision Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx

The amount of naloxone present (0 5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine, however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated Assisted or controlled ventilation should also be considered For respiratory depression, parenteral naloxone is a specific and effective antagonist

Please consult full product information before prescribing

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PHYSICIANS IN THE NEWS

By Lucy Doroshk

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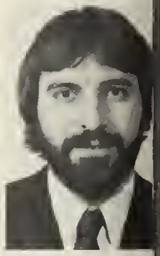
Rohrich

John P. Judson, MD, Benton Harbor, recently returned from Haiti where he spent December as a volunteer surgeon at the Hospital Albert Schweitzer. . . . Berrien County Medical Society named **Gideon Medina, MD,** Niles, president and **Betty Koshy, MD,** St. Joseph, president-elect at the Society's November meeting. **Edwin Vann, MD,** St. Joseph, will continue as secretary. . . . **William Henry S. Moore, MD,** Flint, and his family, were recently named Flint Family of the Year by the Urban League. The Moore family was selected for its achievements and its exemplary attitude toward family life. . . . **Martin L. Norton, MD,** Ann Arbor, has been appointed as consultant to the Anesthesiology and Respiratory Therapy Device Panel of the US Food and Drug Administration. . . . The 1985 Executive Committee for the Physicians of India has named **Inderjit Aggarwal, MD,** Detroit, president; **Bal K. Gupta, MD,** Detroit, Treasurer; and **Jayant I. Shah, MD,** Mt. Clemens, Director of Public Relations. New members of the Board of Governors are: **Mohamed Ansari, MD,** Detroit; **Anil Gupta, MD,** Allen Park; **Jitender Jain, MD,** Troy; **Shabha L. Shah, MD,** Bloomfield Hills; **Sushil Kumar, MD,** Warren; **Ved P. Singia, MD,** Troy; and **N. Venkata Chaiam, MD,** Dearborn. . . . **Constance G. Arnold, MD,** Marquette, appeared recently on the Northern Michigan University television program, "Ask the Doctors." In April, the panel will include **William Addison, MD,** Marquette; **Edward A. Matuga, MD,** Escanaba; and **Gary A. Mikel, MD,** Calumet. Physician coordinator for the program is **Busharat Ahmad, MD,** Marquette. . . . The American Medical Association Resident Physician Section Assembly has elected a new chairman. **Rodney J. Rohrich, MD,** Ann Arbor, will begin his term in July 1985. . . . The late **Martha Longstreet, MD,** Saginaw, longtime member of the Saginaw County Medical Society, was inducted into the Michigan Women's Hall of Fame in February. Hall of Fame members ar honored for their outstanding contributions to society and to the general welfare of the state . . . **Leonard Franklin Bender, MD,** Detroit, was presented the 1984 Alumni Faculty Service Award by Wayne State Universi for his service to the medical community and to the universit . . . The Junior Fellows in District V of the American College of Obstetricians and Gynecologist have elected **Paul C. Nehra, M** St. Clair Shores, chairman for a one-year term. . . . **Melvin Bornstein, MD,** Birmingham, has be named president of the Michiga Psychiatric Society. . . . Norther Michigan University honored **Patti Peterson Holliday, MD,** Dearborn Heights, with an Outstanding Young Alumni Award. She is now Muscular Dystrophy Association Fellow in neurology at Wayne State University. . . . Wayne State University School of Medicine Alumni Associatio is changing its leadership. **Earl Rudner, MD,** Southfield, will become president in May.☐

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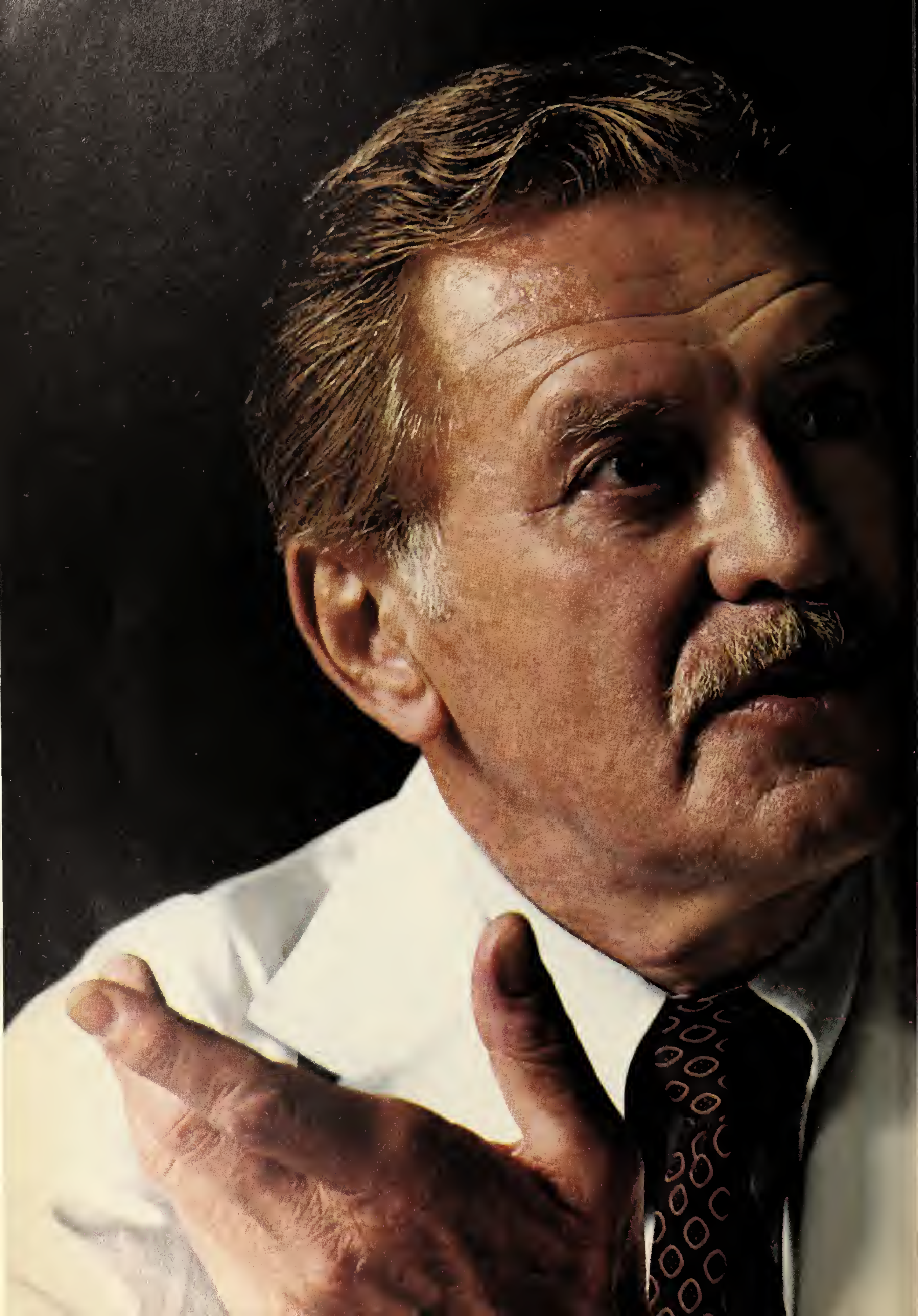

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Please see next page for brief summary of prescribing information.

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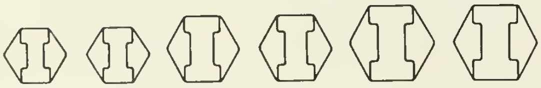

10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® (propranolol hydrochloride) Tablets

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g , dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS

General Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C. INDERAL has been shown to be embryotoxic in anim studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypoter sion, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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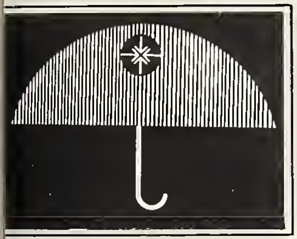

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By Nancy Cranda

Auxiliary offers educational opportunities

Educational opportunities offered by the Auxiliary are many and varied. Most organized county auxiliaries have monthly programs, many of which are educational in nature. They range from speakers presenting information about legislation, career opportunities, health issues, wellness and travel to participatory programs involving diet and exercise, Medicare information, and CPR classes. Leadership training, parliamentary procedures and newsletter writing often is provided for officers and committee chairpersons.

Every year MSMS/A hosts a Legislative Day in Lansing which is open to all members. The day is devoted to education about current legislation and how government involvement is affecting health care and providers. Legislative issues are discussed in each Auxilium newsletter and all members of the state Board receive the *GRA Sheet* outlining current bills and the MSMS positions on them.

MSMS/A holds a Mini-Confluence each Spring—a day of educational programs for county officers. Leadership, parliamentary procedure, community involvement, and public speaking are a few of the areas in which national and state officers prepare county leaders for their responsibilities.

The Annual Session in May is another meeting where educational programs are offered, and time often is allotted at each of the four state Board meetings for programs about pertinent issues. District meetings are held around the state in Spring and Fall and offer to Auxilians many more programs about health-related issues and community programs. Expert speakers are featured at these meetings as well as films, slide-tape presentations and other audio-visual aids.

AMA Auxiliary

The AMA-Auxiliary offers even more educational opportunities to all Auxilians. Each October, county presidents-elect as well as state presidents, presidents-elect and membership chairpersons meet in Chicago for Confluence, a meeting packed with seminars, workshops, and speakers from around the country. These leadership training sessions deal not only with Auxiliary but with the practice of medicine and life in general.

The February National Cluster meeting is a session for incoming state presidents and nominated Presidents-elect. That is followe by the AMA Leadership Conference, a two or three day conference featuring nationally known speakers on medical practice an health care issues. This meeting is geared for AMA members bu is open to Auxilians who wish t take advantage of its valuable content.

There are many resources available from the AMA Chicago offic including a vast reference library films and slide presentations, package programs, and the People Bank, a quick guide to speakers and topics. Another ongoing resource is the Professional Skills Development file, a service to document and recor individual educational experiences with easy access for personal or professional use.

Of course, state and national auxiliaries publish an extensive array of magazines, newsletters, brochures and other informatio geared to increase our knowledge about health care, the practice of medicine and how we ar affected by it all. I hope each of you is taking advantage of as many of these offerings as possible. MSMS/A can be an important resource for any physician's spouse but we each need to make an effort to use the information provided.☐

Mrs. Crandall, Muskegon, is MSMS/A president.

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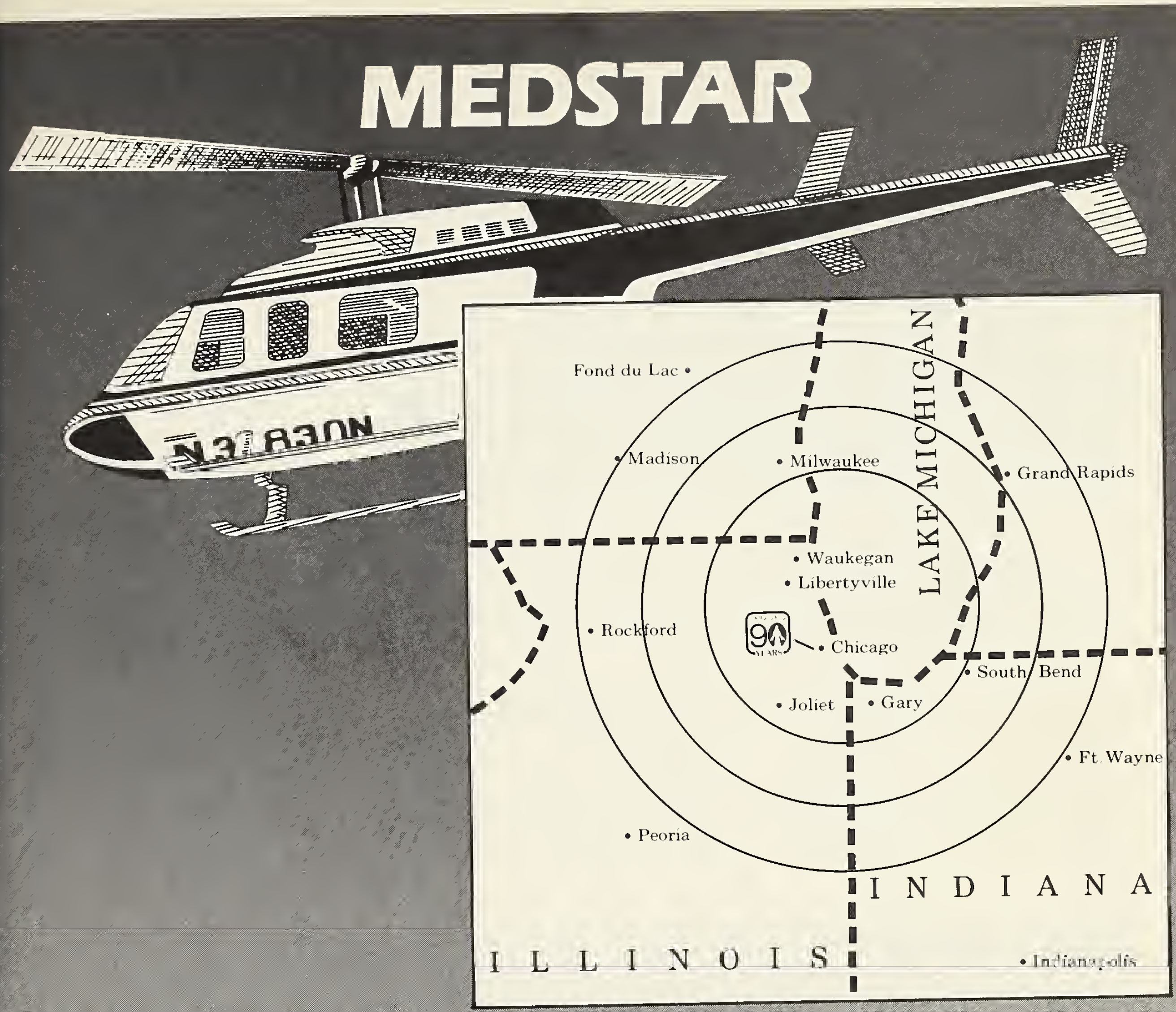
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P. Antonacopoulos, MD — IM
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208 Cherry Hill Trail #301
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17607 Hartwell
Detroit 48235

J. H. Burdakin, Jr., MD — IM/
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Royal Oak 48073

Donna L. Carden, MD — EM/
3879 Carriage Rd.
Birmingham 48010

Wayne W. Charland, MD — P
205 Osceola St.
Lauruim 49913

Gary Chodoroff, MD — PM
26586 Dundee
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Pamela W. Collier, MD — IM
20048 Harper Ave.
Harper Woods 48225

Leon A. Crumley, MD — IM
21700 Northwestern Hwy.
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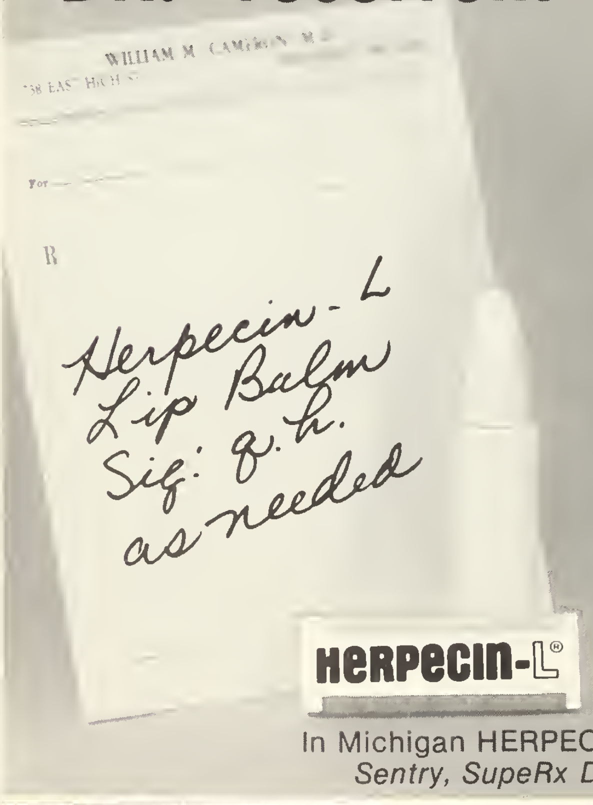

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

April 26-28 — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

March 29 — MSMS/A Mini-Conference for County Officers, MSMS headquarters, East Lansing, contact: Viola M. Heins, MSMS headquarters.

May 6-8 — 59th Annual Session of the MSMS Auxiliary, Holiday Inn, Muskegon, contact: Viola M. Heins, MSMS headquarters.

May 23-24 — MSMS Committee on Maternal and Perinatal Health Gull Lake Conference, MSU Gull Lake Conference Center, Hickory Corners, contact: Katie Brewbaker, MSMS headquarters.

June 16-20 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 18-20 — MSMS Board of Directors Midsummer Meeting, Hidden Valley Resort, Gaylord, contact: William Madigan, MSMS headquarters.

OTHER MEETINGS

April 2-5 — 27 Annual Respiratory Care Symposium, Hyatt Regency Hotel, Dearborn, contact: Caroline Rich, Michigan Society for Respiratory Therapy, PO Box 950, East Lansing 48823 (517) 337-1351.

April 27-28 — Annual Scientific Session and Annual Business Meeting of the Michigan Society of Anesthesiologists, Inc., Hilton Southfield (formerly the Sheraton Southfield), contact: Gary D. Maynard, MD (616) 344-8756.

May 2-3 — Michigan Chapter American College of Surgeons, Resident Surgeons Coller Day Competition and Scientific Session, Henry Ford Hospital and Dearborn Inn, contact: Viola M. Heins, MSMS headquarters.

May 10 — Michigan Associates of the American College of Physicians, Marriott Inn, Grand Rapids, contact: Arnold R. Axelrod, MD, FACP, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235.

May 15 — Michigan Allergy Society Executive Committee Mee ing, University of Michigan, contact: David Seaman, MD, Secretary, Michigan Allergy Society, 8578 Canton Center Road, Canton 48187 (313) 453-2661.

May 17-19 — Michigan Association for Medical Education Annual Meeting, Hilton Shanty Creek, Bellaire, contact: Viola M. Heins, MSMS headquarters.

May 17-19 — Michigan Society of Pathologists Scientific Meetings, Hyatt Regency, Flint, contact: Viola M. Heins, MSMS headquarters.

June 6 — 1985 Annual Meeting of the Greater Detroit Area Healt Council, Incorporated, The Westi Hotel, Detroit, contact: Symond Gottlieb (313) 963-4990.

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ATEGORY I COURSES

chigan Medicine each month carries a list of opportunities in Michigan for doctors medicine to obtain Category I credit toward meeting the requirements of Michigan . Sponsors of Category I programs and courses in Michigan are invited to submit rmation for the monthly calendar.

h listing below, of programs that carry at least 3 hours of Category I credit, indicates ontact person, so the physician can obtain details. Physicians with questions about redited programs may phone MSMS headquarters, (517) 337-1351.

D e: April 18, Pulmonary Rehabilitation Sy opsis. Location: Sheraton Inn, K mazoo. **Sponsor:** Borgess Medical C ter and Southwestern Michigan Area H lth Education Center. **Cost:** Physician - $ .00; Others - $45.00. **Contact:** Kerry El r, Borgess Medical Center, 1521 Gull R d, Kalamazoo 49001. **Approved for:** 5. hours of Category I Credit.

D e: April 20, Perspectives in Cancer M agement Symposium. Location: S th Macomb Hospital Auditorium, 1 00 E. 12 Mile Road, Warren. **Sponsor:** D oit-Macomb Hospital Corporation. F oncologists, internists, gynecologists, ur ogists, family practitioners, general su eons, and other interested physicians a allied-health professionals. **Cost:** phy si ns, $75; physicians-in-training, $25; all d health professionals, $25; registra ti at-the-door, $80. **Contact:** Depart m t of Medical Affairs, (313) 821-6000, e 270. **Approved for:** 7 hours of Cate g I Credit.

D e: April 24, Current Neurology - Clin ic Neurology at the Bedside. Location: Borgess Medical Center. **Sponsors:** Borgess Medical Center & Southwestern Michigan Area Health Education Center. **Cost:** $85.00. **Contact:** William Daam, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit.

Date: April 24, Diabetes Management. Location: Henry Ford Hospital, Detroit. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: April 25-26, 14th Annual Wayne State University Critical Care Symposium. Location: Northfield Hilton, Troy. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma, and Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 557-5009. **Approved for:** 12 hours of Category I Credit.

Date: April 25-27, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: April 25-27, Hospice Dynamics and Realities. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Georgetown University, Hospice of Southeastern Michigan and Michigan Hospice Organization. **Contact:** Community Relations, Hospice of Southeastern Michigan, 22401 Foster Winter Dr., Southfield 48075. **Approved for:** 6 hours of Category I Credit.

Date: April 26, Carcinoma of the Lung: An Integrated Approach. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Cost:** $100 Practicing Physicians, $50 Residents & others. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 7.25 hours of Category I Credit.

Date: April 27 & 28, Eighth Annual Rheumatology Seminar for Practicing

Continued on page 256

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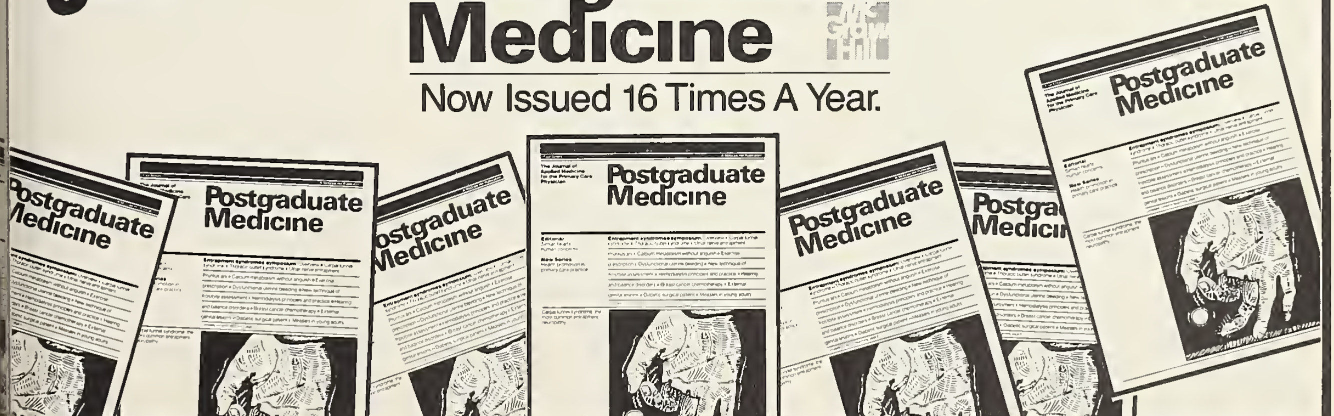

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CATEGORY I/Continued

Physicians. Location: University Health Center, Detroit. **Sponsor:** Wayne State University, School of Medicine, Department of Internal Medicine, Division of Rheumotology. **For:** Family physicians, internists, pediatricians, and other physicians involved in the management of rheumatic diseases. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201, (313) 577-1180. **Approved for:** 9 hours of Category I Credit.

Date: May 2, Problems and Necessity of Unclassical Technique in Work with Adolescents. Location: Ann Arbor. **Sponsor:** The Michigan Psychoanalytic Institute. **Cost:** $60. **Contact:** Michigan Psychoanalytic Institute Extension Division, 16310 W. 12 Mile Road, Suite 204, Southfield, MI 48076 (313) 559-5855. **Approved for:** 6 hours of Category I Credit.

Date: May 2-3, American College of Surgeons. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 13 hours of Category I Credit.

Date: May 2-4, Computed Temography and Magnetic Resonance Imaging. Location: Towsley Center. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine & Health Professions Education, The University of Michigan. **Contact:**Pamela Little, Office of Continuing Medical Education, Towsley Center - Box 057, University of Michigan Medical School, Ann Arbor, MI 48109, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: May 3, 19th Annual Cardiac Rehabilitation & Exercise Testing Conference. Location: Martin Verzi Auditorium - Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center and Institute for Cardiovascular Health and Rehabilitation. **Cost:** Physicians, nurses, exercise personnel - $75, Students - $35. **Contact:** Jeff Morgan, Institute for Cardiovascular Health and Rehabilitation, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001, (616) 383-8342. **Approved for:** 5.5 hours of Category I Credit.

Date: May 6-8, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical Center. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: May 8, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 9, Eating Disorders. Locatio Kalamazoo Hilton Inn. **Sponsor:** Office c Conferences, Division of Continuing Education, Western Michigan Universit **Cost:** $70. **Contact:** Margaret M. Bernhard, Office of Conferences, Ellswort Hall, Western Michigan Universit Kalamazoo 49008. **Approved for:** 6.2 hours of Category I Credit.

Date: May 9-10, Aspiration Needl Biopsy. Location: Henry Ford Hospita **Sponsor:** Henry Ford Hospital. **Contac** Henry Ford Hospital, Continuing Medic Education, 2799 W. Grand Blvd., Detro 48202 (313) 876-3073. **Approved fo** 13 hours of Category I Credit.

Date: May 9-11, Medicolegal Investigation of Death. Location: Hotel Pontchar rain, Detroit. **Sponsors:** Wayne State Un versity School of Medicine Department c Pathology, Office of the Medical Examin ers of Wayne County and the Michiga Medical-Legal Research and Education Association Inc. with the cooperation c the Criminal Defense Attorneys of Mich gan. **For:** Medical examiners, pathologis engaged in medicolegal work, coroner **Cost:** May 9-10 only, $144; May 9-1 $195. **Contact:** Wayne State Universi School of Medicine, Division of Contin ing Medical Education, 4201 St. Antoin 4-H UHC, Detroit 48210, (313) 577 1180. **Approved for:** 15.5 hours of Category I Credit.

Date: May 13-17, Thirteenth Annua Spring Update: Advances in Interna Medicine. Location: Towsley Center, An Arbor. **Sponsor:** The University of Mich gan Medical School, Department of Pos graduate Medicine and Health Professions Education and Department of Inte nal Medicine. **For:** Practicing internists an subspecialists in internal medicine, fami physicians, general practitioner emergency physicians, other subspecialists. **Contact:** Dove Margenau the Towsley Center at (313) 763-140 **Approved for:** 35.25 hours of Category Credit.

Date: May 15, A Case Study Approach t the Evaluation of Common Renal Problems: Prothuria, Hematuria, Recurren Stones, and Recurrent Urinary Tract Infections. Location: Gilmore HEC, Bronso Methodist Hospital, Kalamazoo. **Sponso** Bronson Nephrology and Southwester Michigan Area Health Education Cente **For:** All physicians. **Contact:** Southwester Michigan Area Health Education Cente 4th Floor Stryker Center, 1521 Gull Roa Kalamazoo 49001 (616) 383-6360. **Approved for:** 3.5 hours of Category I Credi

Date: May 17-18, Neurological Updat Location: Henry Ford Hospital, Detro **Contact:** Henry Ford Hospital, Continuin Medical Education, 2799 W. Grand Blv Detroit 48202, (313) 876-3073. **Approved for:** 13 hours of Category I Credi

Date: May 20, A Tangled Web: Conside ation of Brain Death. Location: Hen Ford Hospital, Detroit. **Contact:** Hen Ford Hospital, Continuing Medical Educa n, 2799 W. Grand Blvd., Detroit 48202, 3) 876-3073. **Approved for:** 6.5 hours Category I Credit.

te: May 22, Primary Care of Hand In- ies. Location: Gilmore HEC, amazoo. **Sponsors:** Hand Surgery of uthwestern Michigan & Southwestern chigan Area Health Education Center. **st:** $60. **Contact:** Chris Pearson, Southstern Michigan Area Health Education, Floor Stryker Center, 1521 Gull Road, amazoo 49001, (616) 383-6360. **Ap- ved for:** hours of Category I Credit.

te: May 30-31, Surgical Endoscopy. cation: The Towsley Center. **Sponsor:** e University of Michigan, Office of Con- uing Medical Education. **Cost:** $295 ysician fee; $195 for others. **Contact:** ve Margenau, The Office of Continuing edical Education, The Towsley Center, x 057, The University of Michigan Med- School, Ann Arbor 48109-0010. **Ap- ved for:** 13 hours of Category I Credit.

te: June 5, Fourth Annual Michigan al Cleft Conference. Location: Hilton tel, Grand Rapids. **Sponsors:** Michigan ft Palate Association and Southwestern chigan Area Health Education Center. **ntact:** Janet S. Wilson, Center for man Services, Western Michigan Uni- sity, Kalamazoo 49008. **Approved for:** hours of Category I Credit.

e: June 14-15, Current Topics in hthalmology and Symposium on ucoma. Location: Henry Ford Hospi- Detroit. **Sponsor:** Henry Ford Hospital. **ntact:** Henry Ford Hospital, Continuing dical Education, 2799 W. Grand Blvd., roit 48202 (313) 876-3073. **Ap- ved for:** 13 hours of Category I Credit.

e: June 20-22, 35th Annual Keyport- lord Trauma Symposium. Location: den Valley Resort. **Sponsors:** Wayne e University, Department of Surgery, higan Committee on Trauma. **Contact:** resa Sokol, Wayne State University, partment of Surgery, 6-C UHC, 4201 Antoine, Detroit 48201. **Approved for:** hours of Category I Credit.

e: July 25-26, Collier Penberthy rby Medical Conference. Location: Place Hotel, Traverse City. **Sponsor:** nson Medical Center. **Contact:** Norma vers, Coordinator of Medical Educa- , Munson Medical Center, 6th & dison Sts., Traverse City 49684, (616) -9544. **Approved for:** 9 hours of Cat- ry I Credit.

e: August 24-27, Advances in the nagement of Infectious Diseases. Lo- ion: Grand Hotel, Mackinac Island. **nsor:** University of Michigan Medical ool. **Contact:** Office of Continuing dical Education, Towsley Center - Box , University of Michigan Medical ool, Ann Arbor, MI 48109, (313) 763- 0. **Approved for:** 10 hours of Catego- Credit.

e: August 29-31, Controversies in stetrics and Gynecology. Loca- : Grand Hotel, Mackinac Island. **Spon- :** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Washington, DC 20024. **Approved for:** 16 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: September 16-18, Trauma to the Hand: Diagnosis, Treatment and Functional Restoration. Location: Towsley Center. **Sponsor:** American Society for Surgery of the Hand. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014, (313) 755-4588. **Approved for:** 16.5 hours of Category I Credit.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295. **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. Sponsor: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 20 hours of Category I Credit.

Date: November 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. 18 Category I Credits applied for.

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DEATHS

Alfred L. Aldrich, MD
Ithaca
Doctor Aldrich died December 31. He was 91. Doctor Aldrich was a veteran of World War I. He graduated from Northwestern Medical School in 1925, and was a resident of Ithaca where he practiced medicine for 50 years. Doctor Aldrich had been affiliated with Gratiot Community Hospital and Clinton Memorial Hospital.

I. Marvin Burnstein, MD
Detroit
Doctor Burnstein died January 15, at the age of 82. A well-known surgeon, Doctor Burnstein had practiced medicine with his brother in Detroit since the 1930s.

Robert J. Deering, MD
Grosse Ile
Doctor Deering died January 15 at the age of 72. He was a native of North Dakota, graduated from Wayne State University School of Medicine in 1939 and served in the US Army from 1942-1946. Doctor Deering was a surgeon and was affiliated with Oakwood, Wyandotte General and Outer Drive hospitals.

Otto K. Engelke, MD
Ann Arbor
Doctor Engelke, 75, died February 8. He graduated from Cincinnati University Medical School in 1933. In 1941, he received a Master of Science in Public Health degree from the University of Michigan. He became the director of the Washtenaw County Health Department and assistant professor of public health practice at U-M. He served as president of Michigan State Medical Society (1961); Michigan Public Health Association (1961); Michigan Health Council (1959); and the Washtenaw County Medical Society. He was a consultant on the staffs of St. Joseph Mercy Hospital in Ann Arbor and Beyer Memorial Hospital in Ypsilanti.

Ali Guner, MD
Novi
Doctor Guner died February 7, at the age of 66. A psychiatrist in practice for 35 years, Doctor Guner was a native of Turkey. H was clinical services director at Ionia State Hospital before mov ing to Alpena where he was medical director of Northeast Michigan Community Mental Health Centers.

Vern G. Hunt, MD
Detroit
Doctor Hunt died January 19. H was 87. Doctor Hunt, a gastroenterologist, graduated from the University of Toronto Medic School in 1923. He then joined the staff of Harper-Grace Hospit and retired in 1976.

William E. Jahsman, MD
Ogden, Utah
Doctor Jahsman, formerly of De troit, died January 5, at the age of 91. He graduated from Rush Medical College in Illinois in 192 and had been affiliated with Henry Ford Hospital.

Arthur H. Kretchmar, MD
San Jose, California
Doctor Kretchmar, formerly of Flint, died January 19 at the age of 89. Doctor Kretchmar graduated from Loma Linda Un versity in California. He had served as chief of surgery at St. Joseph Hospital and later at Hu ley Hospital for 18 years. He wa a surgeon in South Africa for some time and helped start a hospital there. After leaving Afric he practiced in Austria and the in Scotland where he became a member of the Royal College c Surgeons of England.

Luther R. Leader, MD
Bloomfield Hills
Doctor Leader, 84, died Januar 31. He was a graduate of Northwestern Medical School. He was former chief of staff at Crittenton Hospital, past president of the Academy of Surger in Michigan, past president of th Michigan State Medical Society and of Wayne County Medical Society.

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IGHT/Continued

ease as new economic realities sggest a decline in physicians' iomes in the years ahead. Paul Srr, in his Pulitzer Prize winning bok, *The Social Transformation* c*American Medicine* writes, "As pbate records for New England cctors in the early 1800s indice, many were enveloped in a tgled web of debt and credit rationships until their deaths. Pctitioners in New England in t 1830s rarely received more tn $500 a year in gross income. Nch of this was paid in kind rher than money."

"The resources of a farm," Enjamin Rush observed in his avice to medical students, "will pevent your cherishing, even for anoment, an impious wish for t prevalence of sickness in your rghborhood."

Perhaps the economic aspects cmedical practice have gained nore significance than is healthy f either the physician or the patnt. Perhaps reflection upon the te meaning of our professional callenges and responsibilities vl lead to a sense of impending com than to a sense of joy for t privilege of being a physician ad the opportunity to serve our ptients with excellence, compssion and dignity.

Equal to the joy of being a pysician is my personal joy of sving as your president this past yar. I thank each and every one cyou for the privilege and the hnor.☐

ATHS/Continued

Snley T. Lowe, MD
Bttle Creek

Dctor Lowe, an obstetrician, cd February 2. He was 86. He gaduated from the University of Nchigan Medical School in 128. He had served both in Vorld War I and World War II. Dctor Lowe was past president cthe Calhoun County Medical Sciety and was affiliated with Cmmunity and Leila Y. Post Nontgomery hospitals in Battle Ceek.

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By Louis R. Zako, M

The plight of the physician

Of the many impressions made upon me during this past year, none has been more dramatic than the prevailing mood of the medical profession. Your president has the responsibility and privilege of meeting with county medical societies, specialty societies, resident physicians, medical students, and hospital medical staffs. The MSMS president also is frequently called upon to address lay groups; to grant radio, television, and newspaper interviews; and to generally represent the Michigan State Medical Society before the public.

Sad to report, the prevailing mood of my colleagues is one of pessimism. The majority of Michigan physicians are dispirited, disheartened and apprehensive about the future.

This prevailing mood is in dramatic contrast with the attitude of the public toward physicians generally. While we often see ourselves as relatively impotent in our dealings with hospitals, third parties, the legislature and industry, others see us as influential, powerful, financially secure and independent. Further, although MSMS and the medical profession do not always prevail in health issues, rarely do the other parties involved act without at least considering our views on such issues. Moreover, surveys over the years demonstrate that physicians generally are held in high regard by the public, leaving union leaders, lawyers, business persons, and legislature with much lower ratings.

Image gap

Why the wide disparity between our own self-image and that of our public image? There is no easy answer to such a question. Nonetheless, permit me briefly to "psychoanalyze" you and me. It seems to me that medical students, residents, and practicing physicians are not immune to prevailing public expectations. While intellectually we physicians understand, for example, that coronary bypass surgery does not "cure" coronary artery disease and often neither prolongs life or even relieves anginal symptoms more effectively than currently available medications, many of our patients look upon the procedure as another of medicine's miracles. Subtly and unconsciously, we also begin to believe that we and our technology are larger than life. When our "miracles" often turn out to be less than "miraculous," our patients sometimes react with anger and occasionally with a malpractice suit.

In my opinion, a greater degree of humility about what we are able to do for our patients would help them and us. After all, every single one of our patients is going to die, regardless of our efforts and regardless of the amount of money spent in an attempt to avoid the inevitable. Further, ho much are we really able to offe our patients with multiple sclerosis, insulin-dependent dia etes, rheumatic arthritis, or mali nant brain tumors?

Although not a therapeutic nihilist, I am becoming increasingly impressed by how well th majority of my patients with se limited illnesses do without my intervention and how little I am able to offer those with chronic illnesses. If we were not so caug up with the often exaggerated claims for the wonders of medic science, both we and our patien would be more content and be ter served.

Economics

I also believe that another sig nificant cause for our present malaise is the gradual rise to prominence of the economic over the non-economic rewarc of being a physician. Without demeaning the importance of economics in medicine (ask an medical student or resident ph sician about the economic aspects of medicine), I would sul mit that whether we make $60,000 to $75,000 or $150,000 to $300,000 ultimate does not affect our degree of happiness and professional sat faction and may even affect it conversely. Which other trade profession has the opportunity on a daily basis to earn a dece and even generous living honestly, to help our fellow men ai women, to ease suffering, to he people die, and, yes, even to dramatically save and prolong l on occasion?

Our relative affluence is a ve recent phenomenon and may largely account for our sense c

Continued on page 2!

Doctor Zako, Dearborn Heights, writes his last president's column here as his year-long term as MSMS president nears its close.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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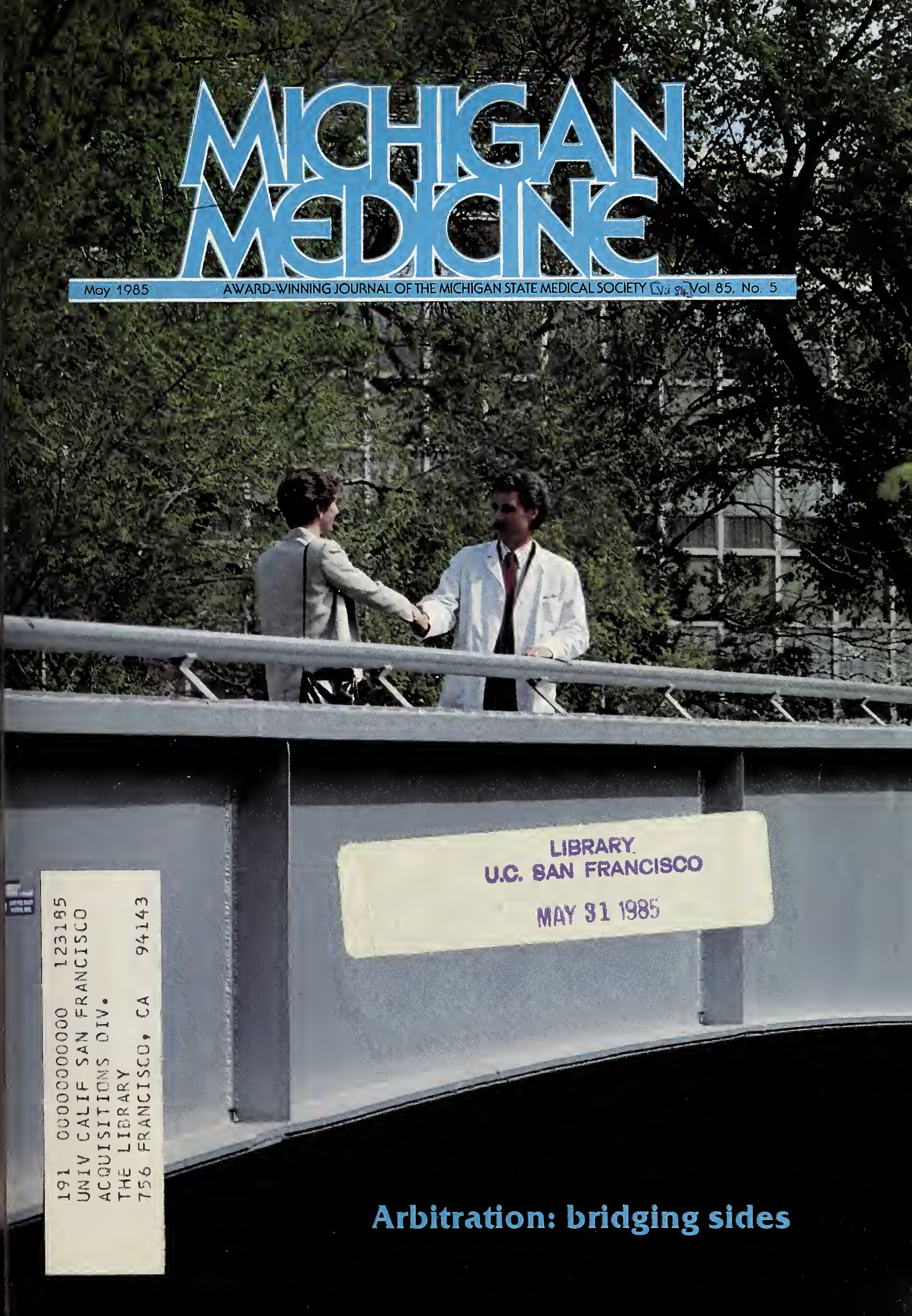
MICHIGAN MEDICINE

May 1985 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY [Vol 84] Vol 85, No. 5



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Arbitration: bridging sides

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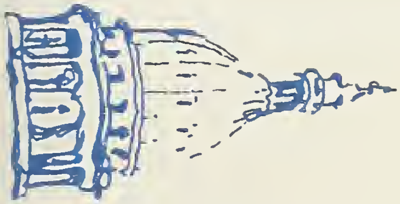

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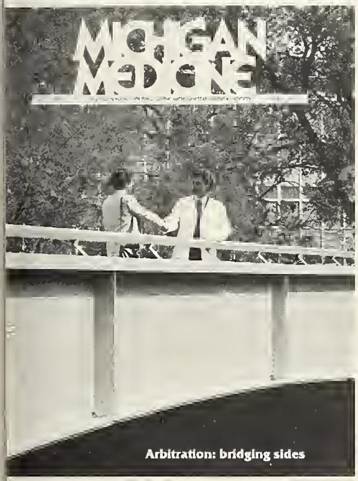

About the cover:
rbitratic n, a means of bringing ogethe parties to a malpractice disput as been strongly rec- omme d as a crisis remedy by he MSM Board of Directors.

Special report

266 A 1984 Supreme Court ruling upheld the constitutionality of arbitration as an alternative to the court/jury system for settling malpractice disputes. What is arbitration and how does it work? The articles in this special report will provide the physician with a working knowledge of the arbitration option: Mary Bedikian; Rhoda Powsner, MD; Randy Watkins.

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In next month's issue of *Michigan Medicine:* The issues surrounding the relationship between hospital medical staffs and administrations will be examined.

By Richard L. Rapport, MD

Hospital bed utilization: an enigma in desperate need of a solution

It is well recognized that there are marked variations in the utilization of hospital beds when Southeastern Michigan (the I-75 corridor) as compared to the remainder of the state. Many Michigan physicians are not aware, however, that similar variations occur between large regions (East Coast/West Coast), smaller regions (geographical areas of other states) and even between hospital markets within the same city. Moreover, variations are similar in fee for service hospital markets in the US, HMOs in the US and Health Care regions in Canada, England and Norway, despite differences in physician supply, organization, financing and cultural and demographic characteristics of residents in these areas.

Since well defined scientific norms do not exist for physician treatment options in such conditions as hysterectomy, prostatectomy, tonsillectomy and coronary by-pass operations, decisions of individual doctors to hospitalize vary substantially, based on subjective experiences. For example, in Maine the likelihood that women who have reached the age of 70 have undergone hysterectomy varies from 20% in one area of the state to 70% in another.

John Wennberg, a medical care epidemiologist who has been studying this phenomenon for more than a decade concludes that subjective factors related to attitudes of individual physicians is as strong a factor as is science. He labels these considerations the "practice style factor" which he believes plays a decisive role in determining what services are provided to an individual patient and in which setting.

He presents a three-pronged plan of action to solve the problem: (1) medical practice in local hospital markets should be closely monitored in order to obtain population based measures of resource allocation, services used and outcome of health care; (2) medical community and qualified researchers should address unanswered questions concerning the effectiveness of common therapeutic interventions and, (3) the medical community must respond by reducing the use of hospitals for marginally indicated conditions in order to deal with the cost-containment problem.

James Sammons, Executive Director of the AMA, considers Wennberg's views both "timely and welcome," but considers "practice style factors" an "answer in search of a question." He believes it offers little help to physicians or researchers trying to identify the causes of the phenomenon.

Other theories

Other explanations have been suggested: (1) Availability and organizational structure of health services are major determinants of hospital use. This suggests that the greater the availability of

Continued on page 274

Doctor Rapport, Flint thoracic surgeon, is a member of the MSMS Board of Directors and Committee on Publications.

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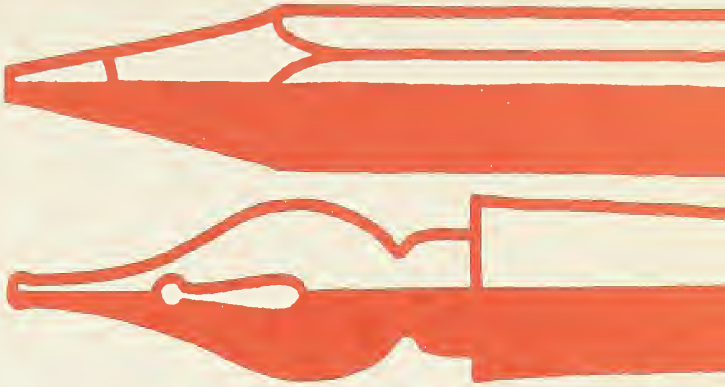

ncontinence n the aged

/ith reference to the article, "In- ontinence in the Aged Patient" the March, 1985 *Michigan edicine*, Volume 84, #3, page 48, by James G. O'Brien, MD, I elieve it advisable in working up n incontinent patient, that a ystoscopy examination be ac- omplished in order to rule out ny pathology in the bladder it- elf, which can cause inconti- ence.

It may be wise also to at least btain a KUB to rule out calculus the cause of irritable bladder. would be far better, however, obtain an intervenous pyelo- ram to give you some idea of e upper tracts as well as the atient's ability to empty their adder.

The article is very interesting. et me congratulate the author n the very well written and ought out article.

George L. Reno, MD
West Bloomfield

alpractice risis remedy

feel that medical societies, ounty, state and national, are issing the point as regards alpractice case settlements and andling of the cases.

Michigan Medicine, February, 985, issue covers the medical rofessional liability situation very ell. I do not feel we should con- ue to "beat a dead horse."

1. It does us no good to keep xplaining the increase in cases ed against doctors, nurses, spitals.

2. It does no good to explain se settlements have increased amount of dollars given.

3. It does no good for the AMA receive reports from a com- ittee on medical liability and fer no course of action.

4. It does no good to keep say- g malpractice is the reason for e increase in malpractice claims. e know that many claims are filed against doctors that have no cause for action. We know that some lawyers are filing claims on cases that happened 18 years ago when the method of treatment then was justified but perhaps now the treatment might be different. We know a lot of these cases are thrown out of court due to no cause for action. But they should not have been allowed in the first place and the people filing the cases should be made to pay the costs when they lose.

5. It does no good to advocate legislative changes that will interfere with a lawyer's income, or a person trying to materially gain money by filing a case without merit.

6. It does no good to say doctors should practice good medicine. The United States doctors already practice as good or better medicine than anywhere else in the world.

7. It does no good to say (and I quote from the *Michigan Medicine*, February '85, journal, "AMA's Liability Crisis") "the real solution to the medical liability problem is to treat our patients to the best of our abilities and in the manner we would like to be treated."

8. It does no good to say malpractice insurance premiums are going to be increased in price.

9. It does no good to point out that Michigan court systems will not allow physicians who are not primary defendants to be released from litigation. Thus, the outlook for Michigan physicians isn't good.

10. It does no good to point out that tort reform is a remedy. Legislators are not going to pass that in Michigan. No fault medical malpractice insurance, in my opinion, will not happen in Michigan.

Now, let's get down to the dollars and cents of malpractice:

1. Many cases are filed against doctors who were not primary care physicians. This entails expense, anguish and lost time to these doctors. If a case is not justified the people filing suit should pay.
2. Doctors can no longer collect enough money to satisfy the people who sue, the lawyers who take the cases and the lawyers who defend the doctors.
3. County, state and American medical societies have tried to influence legislation to no avail.

Solution: The county medical societies, state medical society and American Medical Association should admit doctors cannot collect enough money from the people to pay the millions of dollars that patients and lawyers demand.

The medical societies, groups and individual doctors should advocate and hold out for plan where a general fund would be collected from everybody to take care of the cost of unsatisfied patients and lawyers. This was done for Social Security. Let it be done for the patients, their lawyers and their doctors as well.

No group can collect enough money. Thus, it should be spread out over everybody. Let's get our county, state, national medical societies to advocate a plan of this type.

Hira E. Branch, MD
Flint

By Randy A. Watki

Arbitration: physicians' offer/ patients' choice

The purpose of this article is to provide physicians with information on how to offer their patients the arbitration option in the most efficient and effective manner. In previous issues of *Michigan Medicine*, discussions covered such subjects as ensuring that, when offered the arbitration option, patients didn't feel coerced into signing the agreement (April, 1981) and the basic similarities and differences between arbitration and litigation (June, 1984).

The March 1, 1984, State Supreme Court ruling upholding the consititutionality of arbitration laid to rest challenges regarding the guarantees of due process, whether the arbitration agreement constituted a contract of adhesion and whether the inclusion of a health care provider on the decision-making panel resulted in bias.

From the program's inception the burden of avoiding the arbitration agreement rested with the party seeking avoidance. Even though the constitutionality of arbitration was upheld, the courts have been keenly aware that the patient must be adequately informed about the program before signing the agreement. This has been documented in cases where the court has voided the signed agreement because the informational brochure (patient information booklet) was not given.

This concern about the ability of the patient to make a knowing, intelligent and voluntary waiver of his or her right to litigation is being expressed in a series of recent Court of Appeals decisions involving the offer of arbitration at hospitals. Essentially, the courts have stated that the offer of arbitration must be in strict conformance with the statute. This means that an informational brochure, agreement and an explanation must be given at the time of the offer. For physicians this means:

1) Do not make the agreement to arbitrate a prerequisite to health care.

2) The patient or the patient's legal representative has 60 days to revoke a signed agreement. To do so they must notify you writing. The physician may not revoke the agreement after its execution.

3) Let each patient freely choose whether or not to sign the arbitration agreement.

4) Present the patient information booklet and Form 1BA 100 when you make the offer. Use the version of the booklet designed for physicians' offices (1BA 300 B). Simultaneously provide the patient with the Standar Arbitration Offer.

5) Make sure the agreements are signed by you, or your representative, and the patient. Giv the patient a signed copy of the agreement.

A working knowledge

The Standard Arbitration Offer was developed by the Insurance Bureau in cooperation with the Arbitration Advisory Committee. The purpose of the offer is to provide patients with an immediate working knowledge of arbitration. The offer is printed on the front cover of the patient information booklet.

Physicians should not be too

Mr. Watkins is Program Director, Medical Malpractice Arbitration Program, Michigan Insurance Bureau.

oncerned about the length of
me it takes to offer arbitration.
he 1983 evaluation of the pro-
ram shows that, in hospitals, the
ffer takes between two and five
inutes. The office staff or
nother person designated by the
hysician can present the agree-
ent and booklet to patients, but
hysicians should ensure that the
ated requirements are met.

It is not the physicians' duty,
r their staffs', to become ex-
erts on arbitration. Most ques-
ns can be answered by refer-
ng to the booklet. If not, indicate
the patient the toll free phone
umber of the American Arbitra-
n Association. Above all, allow
e patient the opportunity to
ake an informed decision.

Physicians are encouraged to
ntact the Bureau with ques-
ns or concerns regarding the
bitration program. Contact the
edical Arbitration Program,
ichigan Insurance Bureau, PO
x 30220, Lansing 48909 (517)
3-2984. With informed
alogue, public education and
operation, the arbitration pro-
am can continue to suc-
ed.☐

Here's the standard arbitration offer:

The Michigan Commissioner of Insurance in conjunction with the Arbitration Advisory Committee has approved a Standard Arbitration Offer. This offer is to be used when offering patients the arbitration option.

This offer was developed to help eliminate the differing interpretations that may occur during personnel changes. Additionally, the offer will be printed on the covers of the Patient Information Booklets for easier offering.

For further information please contact: Medical Arbitration Program, Michigan Insurance Bureau, PO Box 30220, Lansing, Michigan, 48909 (517) 373-2984.

Standard arbitration offer

Arbitration is a method of deciding disputes without going to court. The offer of this agreement is authorized under Michigan law to provide the patient with a choice between arbitration or going to court to resolve any health care complaint which may arise.

In arbitration, a 3-person panel made up of a doctor or other health care professional, a lawyer, and a member of the public will hear and decide your case. In most cases, a decision made by the arbitration panel is final and cannot be appealed to court.

Please take a moment to review the agreement. Signing the agreement is your choice. You will receive the same quality of health care whether or not you sign. If you do sign, you have 60 days after you are discharged to change your mind.*

The Patient Information Booklet you receive should answer any questions you may have. Questions can also be answered by calling the American Arbitration Association's toll-free number in the booklet.

*The following sentence is to be used by HMOs and in doctor's offices: You have 60 days from the time you sign the agreement to change your mind.☐

By Rhoda M. Powsner, M

Board of Directors instructs MSMS to support arbitration as means of settling liability disputes

At the October 1984 special meeting on professional liability called by MSMS President Zako, the consensus was that a number of steps should be taken to help alleviate the current medical malpractice "crisis". One of these was vigorous support of the Michigan Arbitration Program which has been declared constitutional by the Michigan Supreme Court.

Enacted during the "crisis" of the mid-1970s, the arbitration statutes were part of a broad program of legislative reform aimed at providing relief so that insurers would not continue to withdraw from the state. It was hoped that the arbitration alternative to the court/jury system would provide a fair, faster, less costly and more predictable method of conflict resolution, one which would allow adequate remuneration for injuries while holding down excessive litigation costs. In addition, it was felt that arbitration would circumvent arbitrary and capricious decisions characteristic of juries in some areas. (See the recently released study by the Rand Corporation's Institute for Civil Justice which notes that job-related injuries and those occurring as the result of defective products receive up to four times as much money in successful lawsuits as similar injuries in traffic accidents and other mishaps.)

The Michigan Arbitration Program got off to a slow start for many reasons: the opposition of the hospital community to the strict requirements for proper implementation of the statutes; the marked hostility of the plaintiff bar which believed patients' constitutional rights were being abridged, and the concern of many physicians that discussion of issues inherent in signing the arbitration agreement might tend to encourage rather than discourage suits. The combination of these factors added to a less than adequate consumer education program and a less than enthusiastic reception of arbitration as an alternative to the courts as a method of resolving alleged malpractice disputes.

Despite these impediments and the constitutional and contractual challenges to the Michigan Arbitration Program, arbitration has been demonstrated to provide a quicker and cheaper forum for resolving medical malpractice disputes than the court/jury system. This conclusion was reached by the Arbitration Advisory Committee during its study of the effectiveness of the program in accordance with the legislative mandate of Public Act 141 of 1975.

Data sources

Data for the study was compiled from uniform claim reports, which the Insurance Bureau requires commercial carriers to submit for each incident of alleged malpractice, and also from records of a representative sampl of cooperating self-insured hospitals, which are not required t submit claims data to the Insurance Bureau. In addition, survey of attorneys, physicians, arbitration panel members, hospital personnel offering arbitration agreements, patients and partie to arbitration were made. In combination with the statistical information, the group surveys assisted in identifying problems and possible solutions.

Claims data

In all, 2,611 claims were analyzed. These included cases which were opened after Janua 1, 1976, and closed between June 1, 1978 and June 1, 1982 Of these, 1,159 were disposed of prior to formal filing either i the courts or with the America Arbitration Association; 1,324 were closed after being filed in circuit court; and 128 were closed following filing with the American Arbitration Associati Sixty-three of the cases filed in court went to trial. These represented 5 percent of all claim filed in the courts and 2 perce of all claims closed in which the was no signed arbitration agre ment. The 36 formal arbitratio hearings which took place duri the study interval constituted 3 percent of all claims filed with arbitration and 6 percent of all closed claims involving a signe arbitration agreement. Plaintiffs were successful in 27 percent court trials and 36 percent of bitration hearings.

Using information from clain

Doctor Powsner is chairperson, Michigan Arbitration Advisory Committee, and has earned a juris doctorate degree.

data, and employing timeliness, cost and consistency of awards as standards by which to measure the comparative performances of arbitration and litigation, it was determined that arbitration required a shorter time from filing to disposition, defense of claims was less costly, and awards were more consistent than in those cases which went through the courts.

Group surveys

The group survey of arbitration panel members revealed their perception that the formal arbitration proceedings were extremely fair. Panel opinions concerning negligence and amount of award were unanimous in 90 percent of the cases.

Over 90 percent of surveyed physicians felt arbitration was more impartial than litigation or mediation plus litigation, both of which they perceived to be extremely biased toward plaintiffs.

Among both plaintiff and defense attorneys, arbitration was philosophically felt to be a better forum for defendants, and the court system was considered preferable for plaintiffs. However, the plaintiff bar's contention that arbitration is strongly biased in favor of the health care provider defendant is at variance both with the perception of fairness of arbitration panel members and with statistical data. The fact that arbitration awards generally tend to be lower than those made in court, although they are more consistent for similar injuries, may be the only factor necessary to explain the plaintiff attorney's concern about the fairness of arbitration as a forum. (Indemnity payments are higher in those cases resolved through litigation than by arbitration for all categories of claims except major temporary illness or injury.)

Cost comparisons

Settlements, awards and legal costs showed some difference between metropolitan and outstate areas, but an unexpected finding was the higher legal costs and indemnity payments incurred by self-insured hospitals when compared to those of the commercially insured hospitals. Legal costs (as defined by defense costs) averaged $150 less per case for commercially insured hospitals than for self-insured ($3,822 versus $4,072), and indemnity payments averaged $1,500 less (median value of $1,000 versus $2,524) for the commercially insured than for the self-insured. The reasons for this disparity were not obvious.

Conclusions

The conclusions of the Arbitration Advisory Committee concerning the Michigan Arbitration Program were as follows: Arbitration is a fair forum for the disposition of malpractice disputes; arbitration's performance to date, even under a cloud of constitutional challenges, indicate it is a fair, less costly and faster system than the court system for resolution of medical malpractice disputes; self-insured hospitals settle more rapidly and at higher average cost per claim than commercially insured hospitals.

Now that the constitutional issues have been resolved and the Michigan Arbitration Program has been demonstrated to be effective, Michigan physicians should urge hospital administrators, attorneys and patients to utilize the arbitration alternative to the court/jury system in the interest of cost containment, timeliness, and fairness. To expedite the process, self-insured hospitals which are not participating in the Michigan Arbitration Program should be encouraged to reevaluate their position. Voluntary participation by those institutions which maintain 50 percent of the hospital beds in the state would be most desirable; however, considering the magnitude of the malpractice problem confronting us legislatively mandated participation of the self-insureds should be considered if efforts at achieving voluntary participation are of no avail.

We believe that the ultimate resolution of the professional liability problem is going to involve several forms of conflict resolution, including the tort system, arbitration, as well as some form of no-fault. In the meantime, as new ideas about how to deal with the "malpractice crisis" are sweeping across the United States, only the people of Michigan have a constitutional medical arbitration program which is a fair and less costly alternative to the court/jury system. MSMS should make an effort to see that it is maximally utilized.☐

Here are approved recommendations

On March 6, the MSMS Board of Directors approved these recommendations of the Legislative Policy Committee.

RECOMMENDATION ONE: That MSMS actively promote arbitration as a cost effective, fair method for adjudication of medical malpractice disputes.

RECOMMENDATION TWO: That MSMS actively support the efforts of the Insurance Bureau to educate the public and provider communities about the arbitration alternative.

RECOMMENDATION THREE: That MSMS actively seek the participation of self-insured hospitals in the Michigan Arbitration Program. If voluntary participation is not forthcoming, a legislative requirement for participation should be sought.

RECOMMENDATION FOUR: That MSMS actively promote the adoption of a provision to arbitrate disputes arising in the course of medical care as part of the contract between consumer and industry sponsored HMOs, PPOs, etc.

By Mary A. Bedikian

Medical malpractice arbitration: a procedural overview

As a response to the malpractice crisis of the early seventies, a reform package was introduced into the Michigan Legislature in 1975. The package unvieled Public Acts 140 and 141 — creative and responsive legislation designed to interrupt the exodus of qualified health care professionals from Michigan. The Acts provided an arbitration component to resolve malpractice claims.

Arbitration is a simple form of legal process. Parties to a dispute agree in advance of a controversy to submit any future disputes to a third impartial person or panel for resolution. Arbitrators evaluate the evidence before them, ascertain the credibility of witness testimony, assess the impact, if any, of expert witness testimony, and arrive at a decision. This decision is considered final and binding, which means that ("de novo") appeal of the decision cannot be undertaken.

Limited rights of judicial review exist to insure continuing protection to the public. Fraud, misconduct and failure to evaluate substantial evidence which causes prejudice to a party fall within the embrace of legitimate reasons permitting judicial intervention.

Although the arbitration process is elective and purely voluntary to the patient, the Act *requires* insured hospitals, HMO clinics and sanatoria to offer it to inpatients, outpatients and emergency patients (after treatment).

The agreement may not be revoked by the health care provider once the patient has executed it. However, the patient is entitled to revoke within 60 days after discharge by notification in writing to the hospital.

Agreement coverage

Arbitration agreements cover the hospital, its employees and independent health care providers who have agreed to arbitrate. They do not cover treatment rendered by health care providers outside the hospital.

The Statute provides that the arbitration process will be administered by the American Arbitration Association (AAA), a non-profit educational entity founded in 1926 to advance the cause of common good through more responsive, humane mechanisms of dispute resolution.

The role of the AAA in connection with the medical arbitration program is two-fold: administrative and educational. As the administrator of the program, it is responsible for developing rules and evidentiary procedures so that cases can be processed in a unified manner. As a corollary function, the AAA conducts training programs in hospital settings for admitting personnel by whom the agreement is offered to patients. These training programs focus on the origin and history of the malpractice arbitration legislation and how the process works.

Of particular emphasis is how hospital admitting personnel must offer the agreement so as to ensure its validity. The law mandates that the patient be given a patient information booklet at the time the arbitration option is offered. This booklet describes the process and the effects of invoking it. A recent change in procedure now includes an offering statement designated on the arbitration agreement. It states that the hospital admitting clerk did, in fact, furnish a copy of the patient information booklet to the patient at the time the arbitration option was introduced. If this procedure is omitted, courts can vitiate the consent of the patient to arbitrate malpractice disputes, and the hospital and medical personnel will be required to defend their actions in the litigation forum.

Ms. Bedikian is Detroit regional director, American Arbitration Association.

ase initiation

A case is initiated when a pa-
ent files a *Demand for Arbitra-
on.* This form should identify in
eneral terms the nature of the
leged malpractice and the re-
iedy sought. Following is an
xample of a standard malprac-
ce description:

lature of Dispute: Medical mal-
ractice occured in that there was
ilure to properly diagnose and
rescribe proper treatment; fail-
re to perform surgery properly;
ilure to provide proper follow-
o, care and treatment; failure to
otain informed consent of claim-
nt with respect to the treatment;
ilure to supervise.

laim or Relief Sought:
750,000.00 plus interest, costs
d attorney fees and corrective
rgery.

The identities of all the re-
pondents must be designated
the demand. Each of the
med respondents must be fur-
shed with a copy of the demand
the time it is directed to the
A office. This procedure serves
a notice requirement similar
the general court rule re-
irement for litigated cases.

A copy of the arbitration agree-
ent executed by the patient
ust accompany the demand. If
e agreement is not available at
e time of the claim, the patient
n execute an affidavit, asserting
that an arbitration agreement had been executed.

The failure of a patient who did not execute an agreement at the time of hospital entry would not preclude the arbitration of a malpractice claim if at the time a claim arose, all parties executed a *submission agreement.* This document permits the submission of a present (rather than a future) dispute to the arbitration forum.

Courts also have the authority to refer appropriate cases to arbitration with an accompanying order directing that the factual issues at stake must be decided by an arbitration panel pursuant to Public Acts 140 and 141.

Appointment of the panel

Determinations of medical negligence and liability, if any, are made by an impartial three-member panel, pursuant to statute. This panel is mutually selected by the parties and is composed of an attorney, a physician or hospital administrator (if the only named respondent is a hospital) or a licensee in another health care specialty (obstetrics, gynecology, podiatry, etc.), and a public member. The attorney on the panel is designated as the chair, and is given responsibilities regarding discovery and pre-hearing matters.

To ensure procedural fairness, the legislature established a procedure which allows the parties to the dispute to submit reasonable questions to an arbitrator candidate within ten days of receiving the candidate's name. Questions must be propounded through the AAA, and are reviewed for appropriateness by the regional director. All acceptable questions then are submitted to the candidate who must respond within five days of receiving the questions.

Once an arbitrator is appointed, he or she is required to subscribe to an oath of impartiality. An arbitrator must disclose any circumstances which might affect impartiality, including bias, financial or personal interest in the result of the arbitration, and any past and present relationships with any of the parties or counsel. This disclosure is communicated to all parties for a waiver. If the disclosure is sustained, the arbitrator will be removed from the case.

Pre-hearing phase

By law, the attorney is given jurisdiction to render decisions on discovery questions which arise prior to the actual oral hearing. The statute requires that discovery commence no later

Continued on page 272

than 20 days after the parties have received a copy of the demand, and must be completed within six months from that date.

During this phase, the parties are governed by the Michigan General Court Rules and the Federal Rules of Civil Procedure. All relevant information should be voluntarily exchanged between the parties in accordance with the limitations of evidentiary rules. Evidence can be subpoenaed, depositions completed, and mental examinations requested.

Pursuant to the statute, authoritative published works on the general and specific subjects in issue may be admitted and argued from, after notice is given to all parties.

The pre-hearing phase should be used to develop not only the skeleton of the case, but the flesh. The advocate's work plan should include written proofs and biographical summaries concerning each witness who will be required to testify. This type of legal blueprint enables the advocate to run through the case quickly but efficiently.

Pre-hearing briefing session

Prior to the oral hearing, the tribunal administrator of the AAA conducts a briefing session with the arbitration panel. The purpose of this session is to familiarize the panel with the issues framed for arbitral determination, and to review the documents filed in the case.

Evidentiary hearing

This aspect of the hearing is considered the most important. The hearings are private, and are attended by the arbitrators, parties, legal representatives and key witnesses.

Parties proceed in the following way during the evidentiary hearing:

1. Opening statement by the initiating party (claimant), followed by a similar statement from the respondent.
2. Presentation of evidence, witnesses and arguments by the claimant.
3. Cross-examination by the respondent.
4. Presentation of evidence, witnesses and arguments by the respondent.
5. Cross-examination by the claimant.
6. Summation by both parties, usually following the same order as the opening statement.

The arbitrators may vary this order on their own initiative or at a party's request. Variance of the procedure normally will affect the burden of proof.

Post-hearing phase

The parties have the right to file briefs, if they believe it will aid the panel in the decision on the merits. Issues in medical malpractice cases generally are complex enough to warrant a summary of the type fulfilled by the brief.

After the panel receives the briefs, the hearing is declared closed. The panel has 30 days thereafter to render a written opinion and award. During this time, the panel meets in executive session to discuss the issues, the testimony and the documentary evidence. At the termination of this session, the chair formulates the decisions of the panel into an "award." The written opinion which states the panel's holding regarding liability is prepared by the attorney member of the panel. The award and the opinion are then circulated for review and execution. A panel member who disagrees with the majority may write and file a dissenting opinion.

The award may include mone damages, remedial care or a combination of these elements. If remedial medical, hospital or rehabilitative procedures are included in the award, the law requires that each element be assigned a current cash value.

Once the award and opinion are received by the AAA, they a distributed to the parties. The arbitration panel has no further involvement with the case nor does it become a participant in court proceedings which may fo low arbitration. The arbitrators a bound by the Code of Professional Responsibility, under whic they labor, to keep confidential any information acquired durin the arbitration process.

Conclusion

Although the use of arbitratio to resolve medical malpractice disputes is of relatively recent vi tage, the use of arbitration as a alternative to litigation is not. Th process has been used success fully for millenia, and can be traced back to the Spartans an the Phoenicians. Its success is predicated in large measure on its informality, privacy, simplicit and speed without compromis ing the elements of due proce and fair play.

In March, 1984, the Michiga Supreme Court, in a virtually un animous opinion, upheld the constitutionality of Michigan's arbitration statute. In so concluding, the Court noted that a bitration is an adjudicative process which grants an entire penumbra of due process righ including the right to a fair and impartial hearing, to plaintiffs' electing the arbitration option. The decision reaffirms that arbi tration is an acceptable and responsive mode for the resoluti of malpractice claims, a final sta in a continuum.

Anyone interested in further information about the program can call the AAA Medical Arbitration Division at this toll-free number: 1-800-482-0660, or (313)964-2525 (not toll-free).

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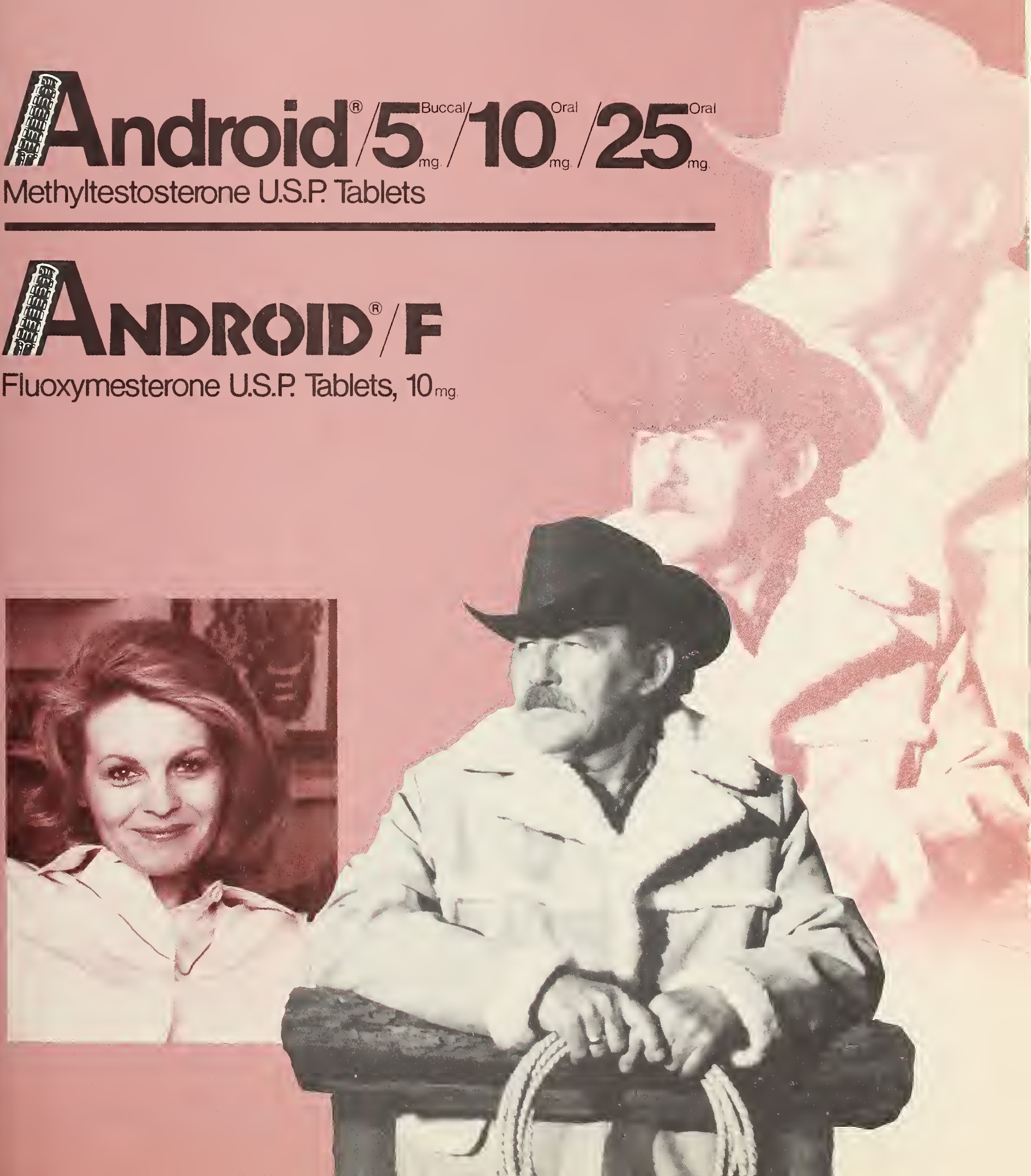

Do you know

**a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?**

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY 1866

HOSPITAL BEDS/Continued

hospital beds, the greater the use of these beds, and has little validity. Although patients in HMOs and PPOs use substantially less hospital care, it has yet to be shown whether or not quality of care is affected; (2) Needs of local populations vary from region to region. Characteristics such as race, sex, marital status, income, education, age and living arrangements (alone or with others) have been shown to explain differences in rates of hospital utilization; (3) Hospital admission rates and lengths of stay have significant impact on both hospital and physician incomes. (Low admission rates may be more economical than long stays.); (4) Regulatory and reimbursement systems are significant factors in creating utilization patterns; (5) Although DRGs will reduce long hospital stays they may also stimulate increased admission rates, especially if high occupancy remains a regulatory requirement; (6) Medical schools and teaching hospitals create long stays partly because caution of house staff members results in more diagnostic testing. This may be an essential for good medical education; (7) Unavailability of extended care facilities causes many patients to wait in expensive primary care beds until long term beds become available; (8) Medical malpractice suits and increasing fees for malpractice insurance result in "defensive medicine," certain to increase admission rates, procedures and lengths of stay; (9) Third party payers have been reluctant to identify outlandish variations in utilization by individual physicians and to solicit the help of organized medicine to eliminate this rape of the system; (10) Patients, particularly those whose health insurance premiums are paid by employers, often pressure the physician for admission to hospitals, believing care to be better and more convenient. Many are totally unaware of cost since someone else is paying th bill.

Only the practicing physician can truly determine community health needs . . .

The above list certainly can be expanded.

Only the practicing physician can truly determine community health needs based on patient population and community resources. When treatment patterns are mandated the quality of care diminishes as the treatment flexibility of physicians becomes more limited.

Medical societies are able and willing to assume the primary leadership role in the reassessment of utilization patterns. At the national level the AMA has recognized this responsibility an has sponsored Economic Grand Rounds, a program designed to educate hospital medical staffs about costs of services they order. The AMA's Diagnostics an Therapeutic Technology Assessment Project uses panels of experts to answer questions raise about the efficacy of medical technology procedures.

It is my conviction that MSMS will take a leadership role in designing research projects to hel solve our utilization dilemma. Blue Cross Blue Shield of Michigan has expressed interest and willingness to help finance such projects.

It is my hope that other third party payers, large purchasers o health insurance, state government, organized labor, the Mich gian Hospital Association and others will join MSMS to help provide solutions to this troublesome problem without impactin in a negative way on the qualit of health care and without destroying our hospital system.☐

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.

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of Michigan
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BLUE CROSS
BLUE SHIELD
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BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT, MICH 48226

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan…a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $1,500 one person
$3,000 family

Dimension III for employees:
Deductible — $250 one person
$500 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too? For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CARRY THE CARING CARD.

Blue Cross
Blue Shield
of Michigan

Meet the first-year legislators in state House of Representatives

Fourteen individuals were elected as first-year legislators in the Michigan House of Representatives last fall. So that our membership might become more familiar with these new public servants, MSMS contacted each of them and asked for biographica information and a response to this question: *What is the legislature's role in promoting the availability of quality health care services in Michigan while at the same time emphasizing the need to contai health care costs?*

Lyn R. Bankes
(R-35) Livonia

Background: Bankes served as legislative aid to Wayne County Commissioner Mary Dumas. She was also elected to the Wayne County Charter Commission, where she served on the Executive Board as treasurer.

On health care: I see my role as a monitor of the health care service vs the health care cost issue. Quality health care is important, yet we must be mindful of the ever-increasing cost of health services. The biggest challenge we will face in the 80s will be how to expend our limited dollars to meet the demands placed on our health care system.

George Furton
(R-75)
Mt. Clemens

Background: Real estate broker/owner of George C. Furton Realty, Inc. for over 20 years.

On health care: I would like to examine the possibility of privately built full service clinics (excluding major surgery) by incentives given through tax abatements, etc. The lower cost of the facilities could then be reflected in lower cost medical care. It is also my opinion that the Legislature should study proposals providing greater protection to the medical professional in cases of unsubstantiated malpractice accusations.

Gregory Gruse
(R-66)
Madison
Heights

Background: Assistant manager of the Green Lantern Restaurant in Madison Heights. Completed pre-law studies and is nearly finished with his work toward a BA in public administration and economics.

On health care: Businesses are leaving Michigan and som are using contract labor to avoid the high cost of benefit among which is the cost of hospitalization insurance. It is important that the legislature and the medical community work together so that health care is not priced out of reac of the majority.

avid Gubow
-67)
untington
oods

ackground: Nine years
racticing attorney in Oakland
ounty, legal counsel - Citi-
ens for Better Care, Lecturer
American Society for Indus-
ial Security, Past Vice Chair-
erson and Secretary/Trea-
urer for the Oakland County
uilding Authority.

n health care: No state-
ent.

rry London
-76)
niths Creek

ckground: Representative
ndon was employed by the
troit Edison Company as a
istomer Representative. His
mily operates Londons Farm
iry in St. Clair County. From
78 through 1982 London
rved as the corporate trea-
rer of the Blue Water Festival,
. As an active Jaycee he was
ected twice as Jaycee of the
ar by the Port Huron Area
ycees.

health care: I feel it is our
sponsibility to act as a
talyst between citizens and
lath care services to insure
ality care while holding
wn increasing costs.

A.J. Hoekman
(R-95) Holland

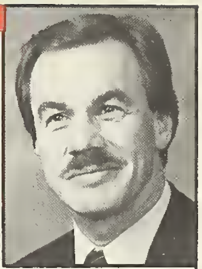
Background: Prior to being elected as State Representative, Hoekman's occupation was in life and health insurance sales for eighteen years. He was past president of Holland Life Underwriters Association; past president of Michigan Association of Life Underwriters and served as legislative chairman for four years.

On health care: I believe the legislator's role is to promote the availability of health care services for all the citizens of Michigan at an affordable cost. We must promote more competition in health care services and stop cost shifting which is very prevalent.

Judith Miller
(R-65)
Birmingham

Background: None provided.

On health care: Good health care is vital. With escalating health care costs, we need to encourage preventative health care and increased home care rather than institutionalization. What does government need to do without infringing upon an individual's choice of care while upholding a high level for care? I'm willing to listen.



James Kosteva
(D-37) Canton

Background: Planning intern with the City of Naperville, Illinois, an assistant planner for the City of Westland and planning director for Canton Township.

On health care: It is essential that decisions made in the private sector begin to dovetail with those made in the governmental arena. Finding an acceptable balance between the competing demands of accessibility and quality on one hand, and efficiency and cost containment on the other, can only occur if this public-private partnership continues. Success depends on communication and cooperation.

Lynn Owen
(D-21) Maybee

Background: Representative Owen was manager of Owen Auto Parts in London Township, and London Township Supervisor and Assessor from 1978 until 1984. He was president, Milan Area Fire Department; vice-chair, West County Ambulance Association; and vice-chair, London-Maybee-Raisinville Fire Department. He is a decorated Vietnam veteran.

On health care: No statement.

Continued on page 278

Jos. Palamara
(D-30)
Wyandotte

Background: Representative Palamara attended Detroit College of Law and earned his Juris Doctor Degree in 1985. He began his career as a restaurant manager in Lake Tahoe and became an administrative assistant with Michigan Recreation and Park Association, Lansing.

On health care: No statement.

Robert Perakis
(R-72)
Mt. Clemens

Background: Member Public Health, Transportation, and Colleges and Universities committees in the House of Representatives. As an Assistant Minority Whip, he is responsible to expedite key roll call votes.

On health care: I intend to ask many questions and do a good deal of listening. I look forward to being an integral part in determining some answers and working with those people who represent the field while I serve as a member of the House Public Health committee.

Claude A. Trim
(R-20) Flint

Background: None provided.

On health care: As a legislator, I need to support legislation that will assure each citizen, whether in public or private employment, or even if they have a small business of their own, that they will be able to obtain the best possible health care for the least amount of dollars. This means we must be able to obtain the facts of costs of medical care and be able to support legislation that will take abuse out and streamline medical care in Michigan.☐

MEDICAL NEWSFRONTS

Kids' asthma camp needs volunteers

Camp Michi-MAC, a summer camp program for asthmatic children, seeks physicians and other health professionals as volunteers. Four sessions, two each at two Detroit-area campgrounds, are planned for mid- and late July. The camps are jointly sponsored by the Michigan Thoracic Society; Michigan Chapter, Asthma and Allergy Foundation of America; Michigan Allergy Society; American Lung Association of Michigan; Michigan Chapter, American Academy of Pediatrics and Metro YMCA. Camp medical co-director Allen Sosin, MD, indicated that volunteer staff are welcome to bring spouses and children to the educational and relaxing camp sessions. Contact camp medical co-director David H. Seaman, MD, to volunteer or to receive details for your asthmatic patients: (313) 453-2661.

Reye's Syndrome update

Two cases of Reye's Syndrome have been reported in Michigan children since March 18. The total number of RS cases reported since October 1, 1984 now stands at nine with three deaths. One of the newly reported cases had a chickenpox prodrome. Influenza-like illness in Michigan appears to remain on the decline. Reports of "flu-like" illness have again fallen below less than twice baseline levels for the reporting period.

Brochures for kidney patients

The National Kidney Foundation has recently published a new brochure entitled "Nutritional Considerations for the Patient on Hemodialysis." It was specifically designed for use in the physician's office as a brief overview of the types of nutritional modifications often imposed on persons being treated with hemodialysis. Also available is "Nutritional Considerations for the Patient Before the Initiation of Dialysis." These brochures ca be obtained through the Nation Kidney Foundation, 2 Park Avenue, New York, NY 10016.

Diving accidents treatment

Divers who enjoy their sport in Michigan waters will have quicker access to emergency medical treatment if they exper ence diving accidents or illnesse thanks to a federal grant being awarded to the Alpena County General Hospital.

The grant will allow the hospi to reactivate its recompression

Continued on page 2

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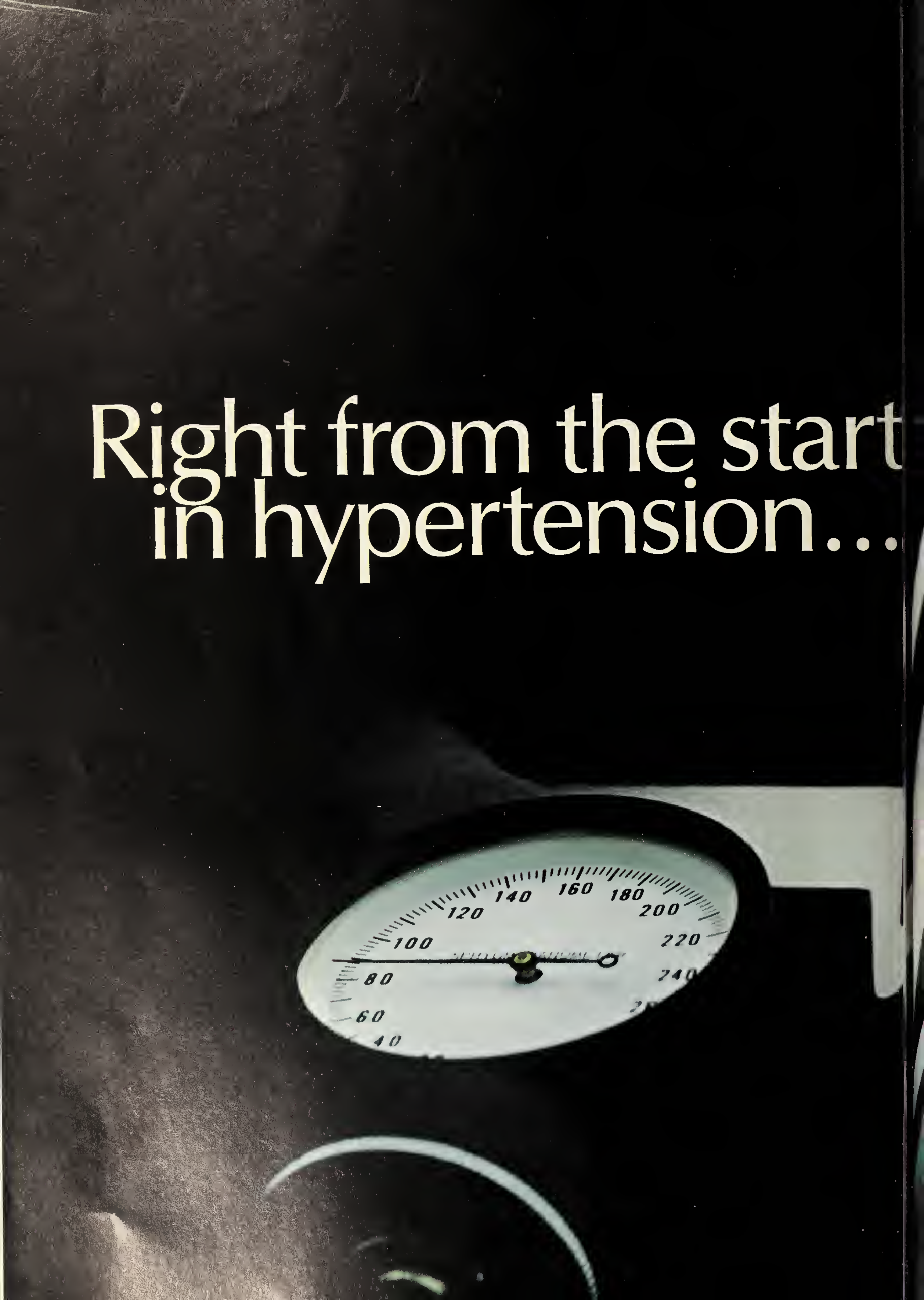
Right from the start
in hypertension...
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140
160
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200
220

Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

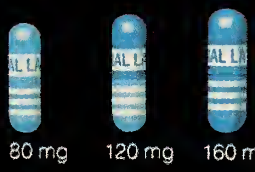
Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

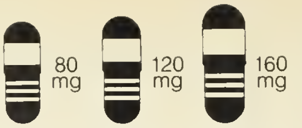
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

For beta-1/beta-2 blockade Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g , dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System lightheadedness; mental depression manifested by insomnia lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute fo INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 64 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few week (see WARNINGS).

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may b increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is no obtained within four to six weeks after reaching the maximum dose, INDERAL LA therap should be discontinued It may be advisable to withdraw the drug gradually over a period c several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are to limited to permit adequate directions for use

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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r hyperbaric, chamber so that ecreational or sport divers may ave access to necessary treatnent within Michigan. Currently, here is no operational multilace chamber here, and patients nust be airlifted to Milwaukee or appropriate medical care.

The project includes training or hospital personnel in operatng the chamber, a specialized acility that provides the only nown adequate treatment for ecompression sickness and air mbolism problems. The hamber can also be used for ther medical treatments.

John McVeety, administrator of ne Alpena County General Hosital, said it is only sensible to retore the chamber to service in ne Alpena area.

"We are very close to the greatst known concentration of shiprecks in Michigan waters in the hunder Bay Preserve," he ointed out.

-M honors Aaron tern, MD, nd traces pediatric ardiology history

More than three decades of ediatric Cardiology at the Uniersity of Michigan will be comemorated May 22 in Ann Arbor. erbert Sloan, MD, will deliver a ibute to Aaron Stern, MD, prossor of pediatrics, senior carologist, former division head nd member of the Department Pediatrics at U-M since 1951. ne occasion will provide an oportunity to reflect on the milesnes that have led to the deelopment of cardiology as a ibspecialty within pediatrics in ichigan, the rapid growth and irrent extent of its services to ildren in the state, and some the unique features of the proam at the University of Michian.

The inception of Pediatric Carology in the state was at the enry Ford Hospital. It was there 1948 that Robert Ziegler, MD, erformed the first cardiac theterization in a child with ventricular septal defect and pulmonary vascular obstructive disease.

In April, 1956 Conrad Lam, MD, working in the same institution, repaired a ventricular septal in a child using heart-lung bypass. In 1984, the youngest known successful heart transplants were performed on a two year old girl and subsequently on a seven-month-old infant. Thus, the seeds planted by Doctor Stern and others matured through continuing cooperative efforts and contributions of thoracic surgery, radiology, and many other related disciplines and allied health personnel.

To underscore the contributions of the pediatric cardiology training program and to mark the retirement of Doctor Stern, the guest lecture on May 22 will be delivered by Norman Talner, MD. Doctor Talner, the first alumnus of the U-M pediatric cardiology training program, is director of pediatric cardiology and professor of pediatrics at Yale University.

Fitness in children

Blue Cross and Blue Shield of Michigan (BCBS/M) and the University of Michigan, with the help of 1,000 school children in Stockbridge Community Schools near Lansing are proving that expanded physical fitness and good nutrition programs improve health of preteen youngsters.

After one year in which the kindergarten through sixth grade youngsters received 30-minute periods of aerobic exercise twice each week and up-to-date nutrition information, tests showed they have: lower blood pressure readings; reduced body fat measurements; increased upper body and abdominal strenth; dramatically increased trunk flexibility; significantly increased cardiovascular endurance.

Joseph Arends, MD, program consultant, said, "We're motivating kids to make proper decisions about diet and exercise that will improve not only the quality of their life, but also the lives of future generations."

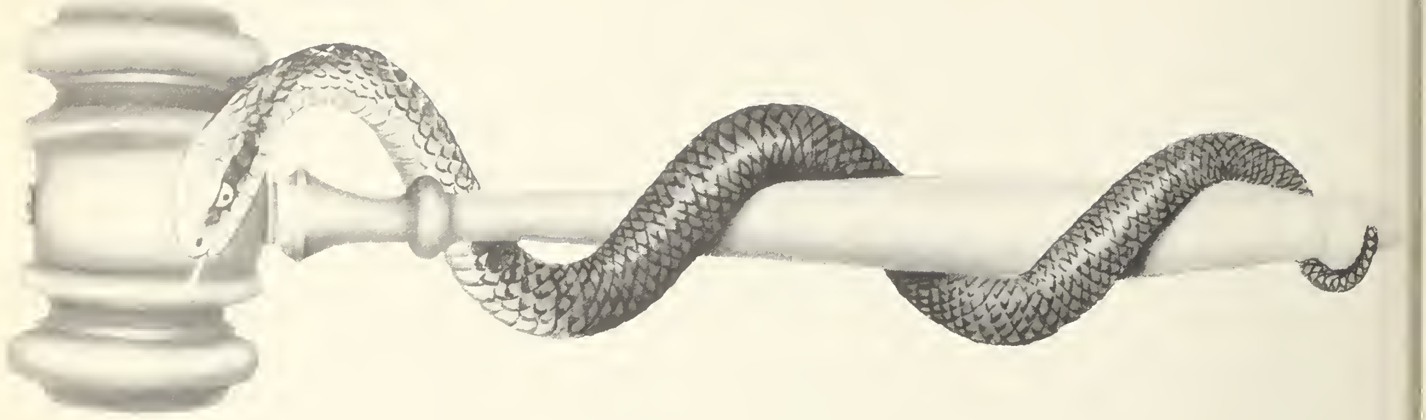
MSMS bioethics library has these topics on file

MSMS is accumulating a library on bioethical issues and wants you to be aware of its objective to collect and disseminate this information. To this end, this "Bioethics Bibliography" will appear in *Michigan Medicine* from time to time. If a title catches your interest, you can obtain an individual copy by contacting the Department of Communication, Michigan State Medical Society, PO Box 950, East Lansing, Michigan 48823. Conversely, if you encounter articles we should know about, send them to Sherry Wellman at the same address.

Titles currently available include:

- "The New Reproductive Possibilities: Seeking a Moral Basis for Concerted Action in a Pluralistic Society"
- "A Verdict Against Doctors in a Jehovah's Witness Case"
- "The Using of Baby Fae"
- "To Suffer a Prolonged Illness Or Elect to Die: A Case Study"
- "New 'Doe', rules clarify treatment guidelines"
- "Death-Life Ethics Debated"

By Judith Marr, Edito



New rules offer redress against frivolous lawsuits

As of March 1, Michigan physicians have stronger redress against the burdens of frivolous lawsuits.

New procedural rules now require Michigan courts to impose sanctions if a judge determines that a lawsuit or pleadings filed with the court were submitted without some reasonable basis in fact or law, or for purposes of delay or harrassment. The new rules follow 1983 federal court rule revisions and are part of legal system efforts to better control time spent in court and costs.

"These new rules," said Monte Jahnke, Detroit, of Kerr Russell and Weber, MSMS Legal Counsel, "apply to all cases, not just those concerning professional liability; and they are a substantial improvement over prior proceedings."

In part, MSMS efforts led to these amendments, he said. In 1981, the Michigan Supreme Court ruled adversely to attempts by the late Southfield physician Seymour Friedman, MD, to sue plaintiffs' attorneys in a lawsuit that was brought against him. The court ruled that it was necessary for Doctor Friedman to prove malicious intent in the case, and found that he was unable to meet that burden.

The court also reiterated that, due to lack of an attorney-client relationship, a plaintiff's counsel owes no duty of care to a defendant physician which could serve as the theoretical basis for a lawsuit alleging negligent behavior in filing a frivolous claim.

Doctor Friedman's failed effort is the most definitive countersuit attempt to date by a Michigan physician.

When the Supreme Court issued its ruling, Justice Charles L. Levin wrote a minority opinion advocating control of nonmeritorious malpractice suits. A that point, MSMS asked the Cou to consider changing the rules on frivolous suits. The Michigan Judges Association also sought changes to help better control court proceedings.

The Supreme Court asked th State Bar to comment and tool all proposals under advisement These efforts contributed to the new rule on sanctions which is among hundreds of changes instituted March 1 by a complete redrafting of the Michigan Cou Rules.

The amendments revise Mich gan General Court Rule 2.114. In part, they provide for sanctio in instances where an attorney submits a false, delaying or frivo ous pleading.

Continued on page 28

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FRIVOLOUS/Continued

The provision

The sanction provision is broadly stated. If awarded, sanctions can include much more than the traditional concept of "costs." That concept has been replaced by that of "reasonable expenses incurred because of the filing of the pleading, including reasonable attorney fees."

In further interpretation of the new rules, Jahnke said the sanctions could also include the expenses of obtaining witnesses, taking depositions and time spent before a suit is thrown out of court.

Mr. Jahnke emphasized that "This new rule does not provide for starting a separate legal action or countersuit against an attorney filing a frivolous case."

"To rule otherwise would set aside long-recognized principles of law," he said. "The Friedman case explored all the options for countersuing, but in the end the rule was that the doctor has no separate cause of action.

"It's difficult for doctors on the receiving end of malpractice suits," he acknowledged. "But if anything, the new law simplifies a doctor's chances of redress because, in an appropriate case, he or she can seek sanctions in the context of the action started by the plaintiff."

Once a court identifies a frivolous action or pleading has been filed (which it may do on its own without waiting for a physician to request such a ruling) the court has no discretion. It must impose sanctions.

"This court rule speaks to all litigants and attorneys, not just those dealing with medical malpractice," Jahnke said. "They can't take a hipshooting approach to lawsuits. Claims have to be more credibly pled."

Generally speaking, he said, this should make complaining and defending parties more responsible.

"It is a direct attack on the frivolous case and it is a significant step. Now a court rule clearly articulates what can be the result of filing a frivolous suit."

Jahnke believes that it is difficult to project how widely the new rules will be used, although it appears there is an increasing tendency by federal judges to award sanctions under the comparable federal rule.

All of the new court rules generally require pleadings to be more specific. This is part of attempts by the courts to better control dockets and to expedite procedures.

Mr. Jahnke's general conclusion is very positive: "Physicians can take some comfort in the fact the judicial system has responded to their feelings of unjust treatment." ☐

A WORD TO THE WHYS

WHY AMA? Commitment to maintaining high quality at all levels of medical education is one of the AMA's proudest traditions. The AMA creates policy for medical education, participates in accreditation activities, and supplies the public with information on medical education issues. Proven dedication to high standards in medical education: it's one more good reason why you should be a part of the AMA.

WHY AMA? Now, for the first time there's a forum for hospital medical staffs to meet nationally to discuss common problems and changes in physician-hospital relationships. The Hospital Medical Staff Section was recently created by the AMA to provide leadership in ensuring quality patient care during this period of massive hospital restructuring. It's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

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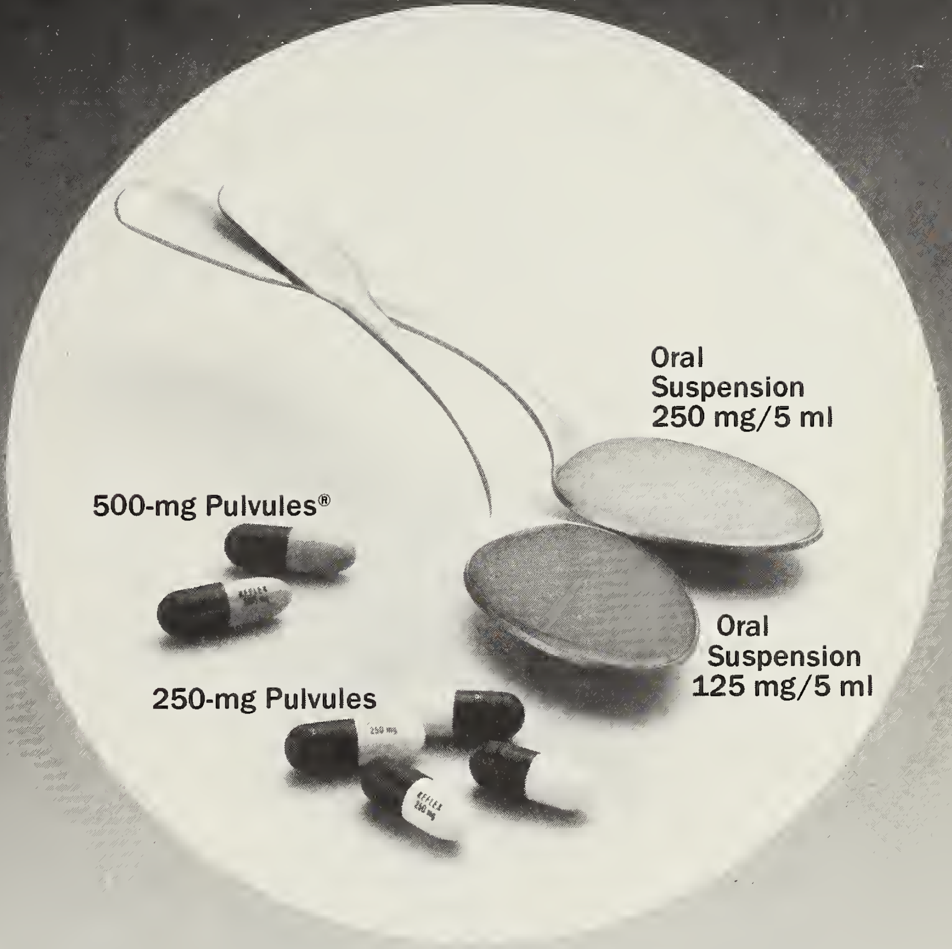
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By Carole Eberly

Representative Hertel hopes to fill medical care gaps in underserved rural Michigan

Hertel, along with six other lawmakers, is sponsoring a nine-bill child protection package, as well.

Enticing new physicians to northern and rural areas of Michigan was a problem in the state for decades. And, like the weather, everyone talked but there was no action.

Until now.

"What we want to do is provide incentives to get students to agree to practice where we need them, in exchange for some financial help with their schooling," said Representative Curtis Hertel, D-Detroit, sponsor of legislation to help pay for a physician's education in exchange for his or her commitment to practice in rural Michigan.

"I think you can make a pretty convincing argument that if we're going to subsidize medical education, it is not unreasonable to ask for this kind of commitment from students," he said.

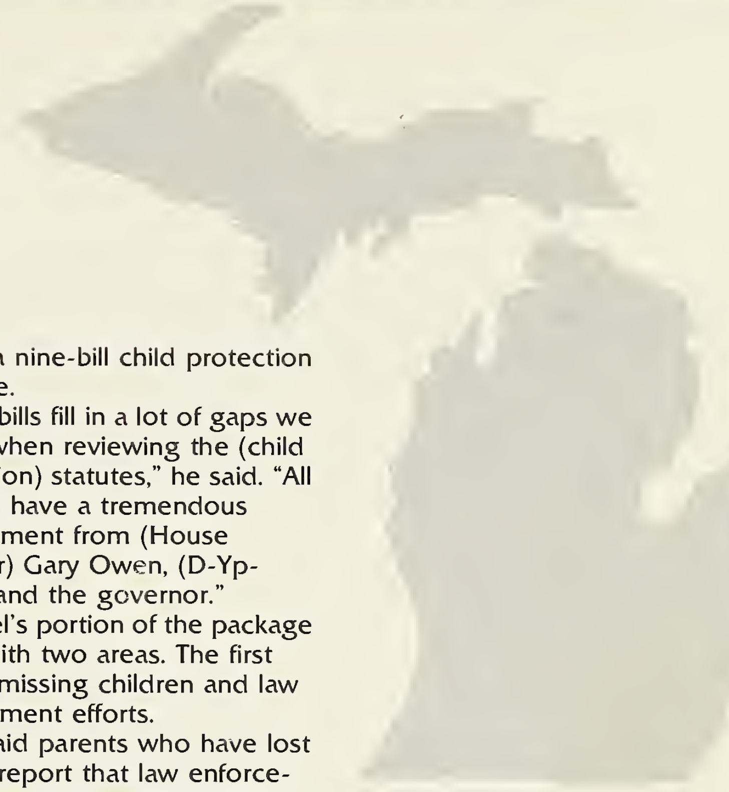
Two programs

Two programs would be created by the bill. One would provide for student grants and the other program would be a loan repayment assistance plan for students who had gone into debt to pay for their education.

The length of medical service required in these rural locations would depend on the amount of financial aid the physician had received. The minimum time commitment would be two years, Hertel said.

The legislation has the backing of all parties involved, he said, including outstate lawmakers and the medical schools.

Ms. Eberly is a Lansing-area freelance writer.



In fact, Hertel believes medical schools will seize this opportunity o show concern about the probem in order to protect their enollment dollars.

"I think they see this as a way o help them make a case for keeping their numbers where hey are at now," he said.

While the program Hertel is pushing is aimed at "coming to he rescue" of persons living outside Michigan's major metropoltan areas, he anticipates some ncillary benefits.

"I think a certain percentage of new physicians will stay in hese areas," he said. "Some will put down roots and decide that s where they want to live and practice."

In cases where physicians nove on, "we'll have someone lse coming in to take their place," he said.

etroiter at heart

Hertel, who surrounds himself with Detroit memorabilia — a 984 Detroit Grand Prix poster, The Road of '84" book about the igers, a giant coffee mug from Hamtramck - is nothing if not a ooster for his hometown. He rew up one mile from where he ow lives on the east side of Deroit. His parents owned a resaurant/bar for 40 years in the eighborhood.

Also surrounding him are hotos — large and small, candid, osed — of his three young chilren.

Perhaps it is the blending of the loseness he feels to his neighorhood and his children that is esponsible for the active role he as taken in child abuse legislaon.

He, along with six other emocratic lawmakers, is sponsoring a nine-bill child protection package.

"The bills fill in a lot of gaps we found when reviewing the (child protection) statutes," he said. "All the bills have a tremendous commitment from (House Speaker) Gary Owen, (D-Ypsilanti) and the governor."

Hertel's portion of the package deals with two areas. The first covers missing children and law enforcement efforts.

He said parents who have lost a child report that law enforcement agencies wait 24 hours before beginning an investigation because the child is assumed to be a runaway.

"These first hours are the most crucial in maximizing the chances of locating the child," Hertel said.

This bill would require immediate investigation of missing children and would set up standardized procedures for reporting disappearances.

Hertel's second bill would make all parental kidnappings a felony. By so doing, law enforcment authorities would be able to use FBI services to locate the missing parent and child.

Currently prosecutors must have proof that the abducting parent left the state before charging him or her with a felony. Without that proof, FBI locating and investigating services cannot be used.

Although Hertel said the package is needed to protect children, he lauded Michigan's legislative record in child abuse legislation.

"Michigan has been a leader in legislative initiatives in the whole area of child abuse and protection," he said. "Our children's trust fund is only one example. We were the first state in the nation to create such a trust fund and have it financed through a checkoff system on state income tax forms."

The trust fund money goes to local agencies dealing with child abuse.

A learning process

With the seemingly endless issues Hertel deals with in the areas of child protection and physician resources — not to mention his duties as chairman of the House Transportation Committee — does he sometimes wish he were somewhere else? Or, does he have his eye on another elected office?

"I'm really quite comfortable here for now," he said, sipping coffee in his office just behind the House gallery. "I like being in the legislature very much. It's still a learning process for me."

And, while some of his colleagues may have become weary and cynical of the whole legislative system, Hertel has his sleeves rolled up, ready to work.

"I'm certainly not tired of it. I don't think I've lost any enthusiasm for the process. I feel good about that," he said. ☐

By Thomas E. Stone, MD

MDPAC chairman says criticism reflects the group's success

The Michigan Doctors Political Action Committee, better known as MDPAC, was formed in 1961, shortly after the American Medical Political Action Committee (AMPAC) was formed. Currently AMPAC has over 50,000 individual physicians as annual contributors. MDPAC has approximately 3,000.

The basic purpose of AMPAC and MDPAC has not changed. Its primary function is to support political candidates on behalf of organized medicine and to educate physicians and their spouses in the political process. However, since the founding of these organizations over twenty years ago, there have been significant changes. When AMPAC was formed in 1961, for instance, there were just two political action committees whereas today, there are approximately 3,500.

The success of political action committees can perhaps be reflected by the fact that they are now being criticized by an increasing number of opponents. This criticism appears to reflect the degree of success of the various PACs. The success of AMPAC and MDPAC by almost any measurement makes them leaders in this particular movement.

A growing organization

At this point in time, I actually feel we might consider changing the name for we are no longer just a committee, but rather a growing organization involved in many aspects of political action. Individual state PAC activity has by and large in almost every state, expanded well beyond the support for political candidates.

Money, of course, is the "mother's milk of politics." In every campaign and in increasing amounts, money is critical to victory. Our efforts along these lines have been successful, although there never appears to be enough for all the needs which arise. Perhaps even more important, however, is the fact that we have achieved an increasing degree of physician and physician spouse involvement in the political process. MDPAC exerts considerable effort in educating individual physicians about the political process. This is done through one-on-one communication as well as through seminars and participation in a biannual meeting in Washington, DC.

The interests of physicians are best served by electing worthy candidates who understand and appreciate the unique contributions medicine has made to the health of the American people. MDPAC continues to stress that the personal relationships doctors build with their legislators are really what "opens the doors."

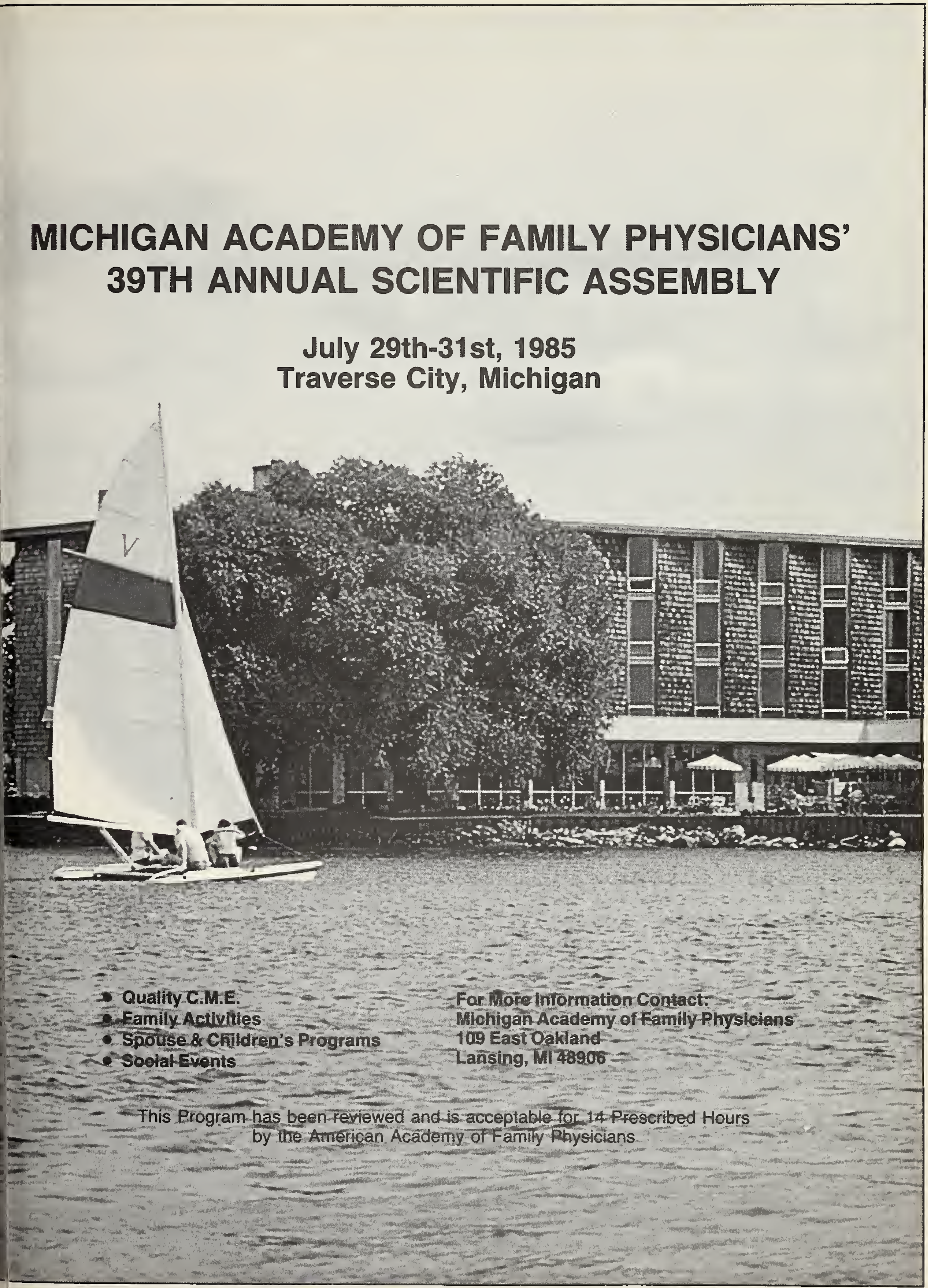
MDPAC continues to operate very carefully within the constraints of medical and state election laws. We continue to cooperate with AMPAC in activities such as benchmark surveys, done to obtain statistical data for candidates. Also, we continue to offer research assistance, which allows us to help candidates in the planning and conduct of thei campaigns.

New activity

One of the new activities of the MDPAC Board has been the publication of *Michigan Roundup* a summary of the legislative week. This currently is mailed to sustaining members and hopefully its distribution will be increased to include more members of MDPAC and MSMS. The enthusiastic acceptance of this publication has been gratifying.

I feel confident reporting to you that MDPAC continues to function very effectively as the political action arm of MSMS.☐

Doctor Stone is chairman, Michigan Doctors Political Action Committee.



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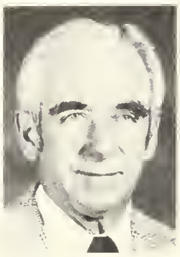
PHYSICIANS IN THE NEWS

By Sheri W. Greenho
Managing Edit

Benkert



Carpenter

Dugan

Fenton

McDonald

James L. Fenton, MD, Bay City, recently was re-elected president of the Michigan Board of Medicine for 1985, a post he has held since 1983. Doctor Fenton is certified in radiology and nuclear medicine and is a member of the executive committee of the Michigan Radiological Society and a fellow and counselor of the American College of Radiology. ...New president of the American Council on Transplantation is **Franklin D. McDonald, MD,** professor and vice chairman of internal medicine at Wayne State University School of Medicine. ...**Louis E. May, MD,** Howell, recently was appointed to the Cleary College Board of Trustees. ...The Friends of Mercy of Mt. Carmel Mercy Hospital recently honored **William S. Carpenter, MD,** Southfield, for his significant contributions to the health care field. Doctor Carpenter is a founding member of the Detroit Surgical Society, Detroit Surgical Association and was chief of surgery at Mt. Carmel and Harper Hospitals. ... The US Defense Department recently awarded **Chris J. Zarafonetis, MD,** Ann Arbor, its Medal for Distinguished Public Service for his work in North Africa and Italy during World War II and his contributions to the military physician recruitment program. ...The American Academy of Family Physicians has announced the appointment of three MAFP members to serve on its committees: **George A. Dean, MD,** Southfield, will serve on the Committee on Health Education; **Harold F. Kendrick, MD,** Pontiac, will serve on the . Daly, MD, Albion, has been appointed to the American Hospital Association Council on Hospital Medical Staffs. ...The Michigan Occupational Medical Association has announced its elected officials for 1984-85. They are: **Jack E. Benkert, MD,** Grand Blanc, president; **Robert S. Rhodes, MD,** Ypsilanti, president-elect; **Howard J. Sawyer, MD,** Farmington Hills, vice-president; **Donald J. Sherman, MD,** Dearborn, secretary/treasurer. ...WNMU-TV, Northern Michigan University's Public TV station will feature **L. Jay Turkewitz, MD,** Marquette; **J. Marc Himes, MD,** Marquette; and **Richard A. Bohjanen, MD,** Ishpeming on its panel for "Ask the Doctors" in May. ...**Allan J. Goldstein, MD,** Battle Creek, has been appointed chairman of the Committee on Quality Assurance for the American Academy of Otolaryngology. ... **Shreyaskumar Patel, MD,** Southfield, and **Vanda Patel, MD,** Southfield were recently honored with "Appreciation" awards by Southfield's Civil Defense organization for their participation as medical advisors. ...New officers have been installed at the Calhoun County Medical Society. They are: **John B. Huntington, MD,** Battle Cree president; **John G. Girardot, M** Battle Creek, president-elect; **James J. Maurer, MD,** Battle Creek, vice president; and **Robe E. Wilkins, MD,** Battle Creek, secretary and treasurer. ...**Alber R. Dugan, MD,** Grand Rapids, wa named president-elect of the Kent County Medical Society. ... Shiawassee County Medical Society has elected **Timothy D. Oliver, MD,** Perry, president. ...The Blue Water Mental Health and Child Guidance Clinic honored **William C. Cleland, MD,** Port Huron, at their 34th annua meeting held in February. Doct Cleland received the Franklin H Moore, Sr. Memorial Award for his efforts on behalf of mental health. ...**Dale Williams, MD,** Muskegon, was part of a four-member team that went sent t Ethiopia to insure grain delivery from International Aid, Inc., a no profit relief organization. ...**Donald J. Aiken, MD,** Okem has been named president-ele of the Ingham County Medical Society.☐

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Medical malpractice: the distrust between the medical and legal professions

Physicians thinking of the legal profession today tend to generalize from their impressions of professional liability lawyers to all lawyers. Even though physicians consult lawyers for tax advice, financial advice and estate planning, physicians seldom think of "those lawyers," probably because they do not evoke the strong emotions aroused by malpractice lawyers.

The doctor complains

Physician defendants feel their professional pride and self-image to be under attack. Interrogatories, letters, telephone calls and similar interruptions provoke, pester, and anger them, to say nothing of how they feel about giving depositions or going to the courtroom.

The next reaction is a combination of fear and insecurity. Since so many suits are far from clear-cut examples of obvious negligence, a suit over a particularly vague or unclear event evokes a diffuse fear that if an action which seemed perfectly appropriate at the time led to a suit, any action could result in a suit. When one suit turns on a question of documentation, physicians feel insecure about all of their record-keeping on all of their cases up until this time. When a suit arises over a disputed medical judgment, physicians worry that all their past judgment calls might be construed as questionable. If a suit turns on informed consent or some other issue requiring knowledge of the law, physicians suddenly realize that they do not know how to protect themselves from future suits. In the absence of specific reassuring information to the contrary, physicians vaguely conclude that they are obligated to do absolutely every test or x-ray possible for self-protection.

Loss of security

Suits also deprive physicians of any sense of security they might once have felt about their relationships with patients. In some cases, litigious patients can be identified in advance, and at least the physician has the reassuring sense of having predicted a suit, but in most cases, physicians think they have good relationships with their patients and are shocked when faced with a suit. Thus physicians are now feeling insecure about all relationships with patients, and their old-fashioned expectation of warm, reassuring, mutually satisfying relationships with patients are being transformed to fear of confrontation by potential enemies.

Physicians are astonished and shocked at the way medical issues are viewed by lawyers, and at how a plaintiff's version of an incident may sound. Furthermore, it is shocking to discover the way lawyers perceive and portray medical decisions, statements by physicians, and medical therapy in general.

Frustration

Next come feelings of frustration. It is frustrating to find lawyers attempting to reduce complex medical decisions to simple questions of right and wrong. It is also frustrating to realize that in many if not most instances, there are no clear-cu standards of practice against which physicians may securely measure their actions. The standard of practice presented by a ivory tower academic will often be unrealistically high, and the standard of practice parroted b a legal prostitute with no real expertise in the medical area at issue will often be unrelated to the real world of medical practic Physicians are also frustrated when lawyers attempt to portra the art of medicine as an exact science. It seems that lawyers ca only deal with medicine when i is made to appear a science, sinc it is almost impossible to prove malfeasance in the practice of art.

Doctors are humiliated by a suit. Certainly they feel outclasse and inadequate when lawyers question them sharply, and the are shocked to find themselves left at a loss for answers, sputtering lame-sounding explanations even when they are in th right. Doctors even resent furth being cross-examined, having their judgment impugned, and knowing that these lawyers go

Continued on page 2

Doctor Adelman is a Detroit pediatric surgeon. Mr. Friedman and Mr. Simons are members of the law firm Simons, Deitch, Tucker, Weisman, Friedman and Trogan.

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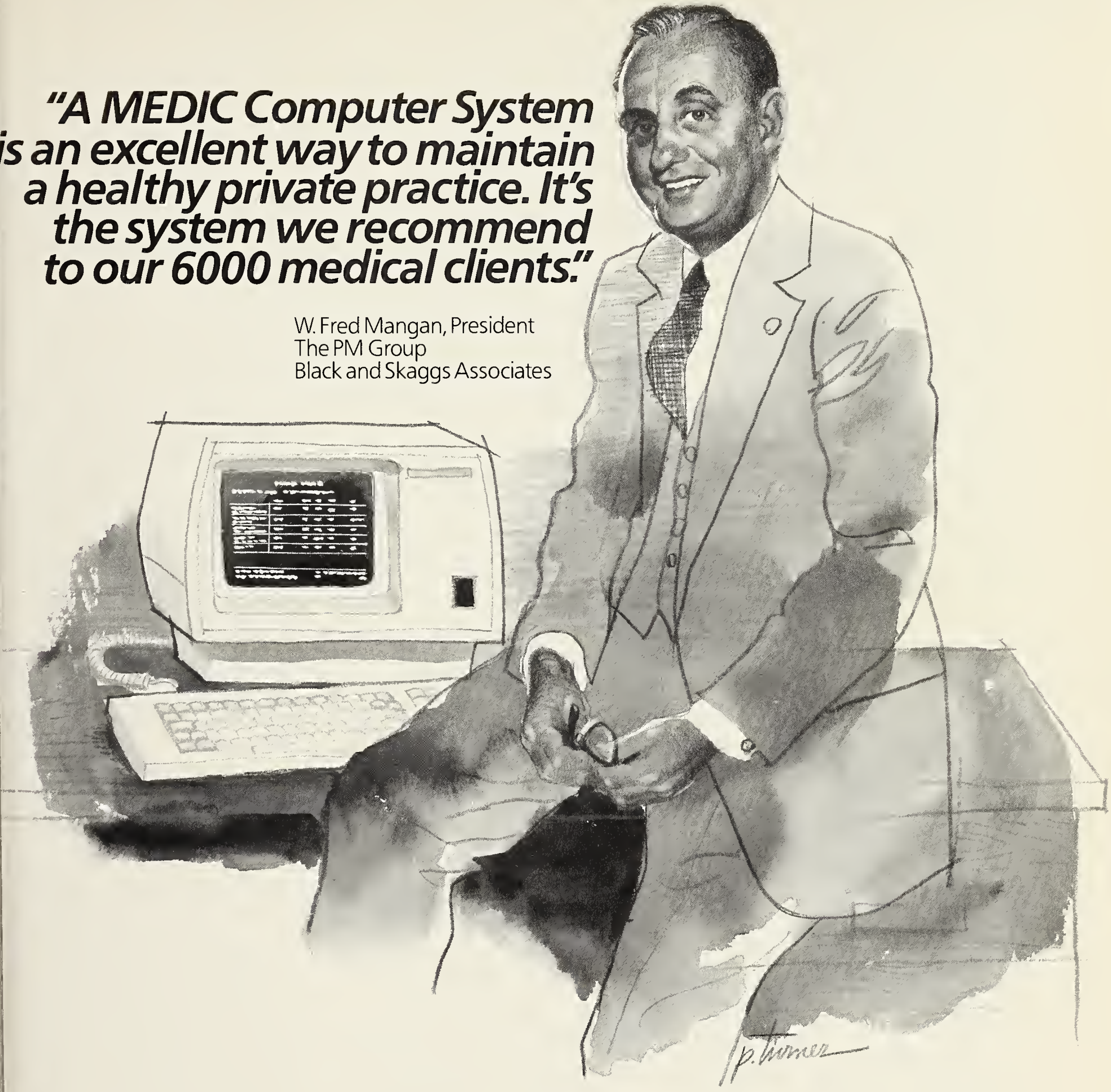

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all their impressive sounding information from reading in the library and that they actually have no idea what the practical problems are in applying what they have read.

Doctors are angry

Doctors are angry about many things, but informed consent issues may present some of the most global threats, since physicians now feel barred from ever offering warm reassurance, softening hard truths or saying what they must to persuade patients to undergo unpleasant but essential procedures.

Doctors become angry at all lawyers and the whole legal system when they feel obligated to do every test and study known to man for every patient. This is even more problematic today because insurers, employers, unions and most of the rest of society are pushing physicians to be more cost-conscious and to radically modify established practice patterns wherever possible for more effective cost containment. With an escalating need to do more tests driven by the legal system, this puts physicians in a classical double bind.

Physicians are especially outraged at those members of the plaintiff's bar who believe that they must act as watch dogs for patients' interests or doctors will harm patients. In essence, lawyers thus sell themselves to society as the "good guys," as opposed to doctors, who must be the "bad guys." The whole picture does very little to evoke warm feelings in the hearts of doctors toward these or any other lawyers.

The lawyer reflects

- A young, intelligent, spunky attorney faces the possibility of desperate illness for the first time in her twenty-five years. She complains to a friend, "the worst part is that he won't tell me what I have. It's like he's afraid because I'm a lawyer and he doesn't want to commit himself. I'm scared."
- In the 1982 movie blockbuster, The Verdict, the "malpractice" defense lawyer, James Mason, rigs newspapers, suppresses evidence, wires the judge, and uses a female attorney to seduce and spy on the victim's lawyer, Paul Newman, in the course of trial.
- The media continues to report that the historic mutual respect between doctors and lawyers continues to disintegrate — no wonder.

Now, an analysis of the problem:

Distrust causes lawsuits

In recent years there has been a proliferation of medical malpractice lawsuits. At the very heart of this litigation is a lack of trust. It has come about in part, because of four related causes.

Above all, patients feel that doctors are really *too busy* to care about them. There is a belief that doctors will not tell them what is "really" wrong with them for fear of getting blamed if this does not turn out to be the case. There is also a sense of resentment when a patient is put through a barrage of tests. Patients often feel that the only purpose behind these tests is to increase their doctor's fees.

At the very heart of litigation is a lack of trust.

Another area perpetuating a lack of trust is purely geographical. The Census Department reports that the average person frequently changes his residence. In the one year period between March, 1981, and March, 1982, 37 million people changed their address in the United States. Formerly one doctor would serve a whole family from birth to death, now it is far more common for a doctor to see a patient just a few times. The problem of patients in transit puts a greater burden on doctors to build a relationship of trust during the course of relatively few visits by a patient. If the bond does not develop, the patient is more demanding and less understanding in his dealing with his physician. In turn the patient may decide to turn to a lawyer to remedy any dissatisfaction with his or her doctor.

Working in the same way as the geographical factor is the impact of HMOs, PPOs, and other corporate health plans. As patients are given changing incentives to join plans, drop plans an switch plans, relationships with doctors suffer.

A fourth contibuting factor is the trend towards "consumerism in the medical market place. Ever day television presents a new show about the innerworkings c a hospital or about how the ide doctor interacts with his patient This hype reinforces the patient suspicions about their own doctors. Moreover, more informatio about medical procedures and treatments is being made available now to the public-at-large through the media.

Lawsuits cause antagonism

The lack of trust has increase the number of medical malpractice lawsuits. These lawsuits hav in turn generated antagonism between doctors and lawyers. Ther are a number of reasons for thi hostility.

A lawyer, like a doctor, must use his or her best efforts in representing any client with a potential claim. Antagonism develops because of the belief by physicians that many lawsuits a instituted without any investigation of their merits before the su is filed. One reason why a suit may be filed without extensive investigation is that clients frequently come to their attorneys immediately before the statute of limitations is about to run ou on their claims. Failure on the pa of the attorney to act quickly a tually might give rise to a malpractice action against the atto ney brought by the newfound client.

Another area which generate antagonism between the profe sions is the difficulty encountere in obtaining medical records before a lawsuit is filed. This may

Continued on page 3

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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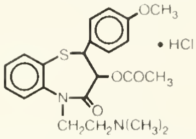
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis- The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1), asthenia (1.2%), AV block (1.1%). In addition, the following e s were reported infrequently (less than 1%) with the order of pres tion corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, brad dia, palpitations, congestive heart fa , syncope.
Nervous System	Paresthesia, nervousness, somnol , tremor, insomnia, hallucinations, and amr
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vom mild elevations of alkaline phosphatase, T, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosens y.
Other.	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episod of vasospastic angina developed periods of transient asympto ic asystole approximately five hours after receiving a single 6 g dose of CARDIZEM.

The following postmarketing events have been reported quently in patients receiving CARDIZEM: erythema multiforme kopenia; and extreme elevations of alkaline phosphatase, T, SGPT, LDH, and CPK. However, a definitive cause and effect bet en these events and CARDIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been li d. Single oral doses of 300 mg of CARDIZEM have been well tole d by healthy volunteers. In the event of overdosage or exagg d response, appropriate supportive measures should be emplo in addition to gastric lavage. The following measures may be consi d:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If re is no response to vagal blockade, admi er isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed h-degree AV block should be treated wit ar-diac pacing.
Cardiac Failure	Administer inotropic agents (isoprote l dopamine, or dobutamine) and diuretics
Hypotension	Vasopressors (eg, dopamine or levart ol bitartrate).

Actual treatment and dosage should depend on the severity e clinical situation and the judgment and experience of the tr g physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 kg and from 560 to 810 mg/kg, respectively. The intravenous LD in these species were 60 and 38 mg/kg, respectively. The oral L in dogs is considered to be in excess of 50 mg/kg, while lethali as seen in monkeys at 360 mg/kg. The toxic dose in man is not k n, but blood levels in excess of 800 ng/ml have not been asso ed with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic o-nary Artery Disease or Angina Pectoris at Rest Due to o-nary Artery Spasm. Dosage must be adjusted to each pa t's needs. Starting with 30 mg four times daily, before meals at bedtime, dosage should be increased gradually (given in ed doses three or four times daily) at one- to two-day interval ti optimum response is obtained. Although individual patient ay respond to any dosage level, the average optimum dosage ge appears to be 180 to 240 mg/day. There are no available data c m-ing dosage requirements in patients with impaired renal or h tic function. If the drug must be used in such patients, titration sh be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort te anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be ely coadministered with short- and long-acting nitrates, bu re have been no controlled studies to evaluate the antia nal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 DC 0088-1771-47) and in Unit Dose Identification Paks of 10 DC 0088-1771-49). Each green tablet is engraved with MARION ne side and 1771 engraved on the other. CARDIZEM 60-mg ed tablets are supplied in bottles of 100 (NDC 0088-1772-47) and nit Dose Identification Paks of 100 (NDC 0088-1772-49). Each ow tablet is engraved with MARION on one side and 1772 on the er.

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prevent an attorney from adequately investigating the merits of a claim before instituting a formal lawsuit, so, many attorneys file without sufficient investigation. The act of filing the suit, unfortunately, will make the physician feel this casts doubt on his or her ability to practice medicine.

Frequently a patient's doctor maintains that all records are confidential and that the doctor has no right to release the medical records to the patient's attorney. This is a misconception, as the right to assert the confidentiality of the records is the right of the patient and not of the doctor.

Another area that generates lawyers' antagonism towards doctors is the general lack of available expert medical witnesses. The lawyer preparing for trial must frequently wrestle with the problem of finding an expert witness who is willing to testify against a physician colleague.

There is a belief on the part of physicians that the contingent fee system perpetuates frivolous lawsuits. The argument is that the more stake a lawyer has in the controversy, the more likely he or she is to pursue meritless claims against doctors. That criticism ignores the problems of a tremendous number of injured people who are unable to afford the cost of litigation. Without the contingent fee system they would be unable to seek redress for their injuries.

Conclusion

While an analysis of the lack of trust between the legal and medical professions does little to directly solve the problem of lawsuits directed at doctors, it nonetheless points out areas of differences and should increase the level of understanding that is most lacking. One would think that these two major professions should be able to work together. First, however, they must see the importance of such efforts—and that requires an understanding of the factors which have caused the breach in their relationship.

Perhaps a greater understanding between the professions could reduce the high cost of medical malpractice insurance, eliminating some of the lawsuits directed toward doctors. If the cost of insurance could be lowered, it is conceivable that some of the upward pressures on medical costs may diminish. Moreover, with doctors in a less defensive posture it is possible that the sheer number of unnecessary but litigation-minded tests may be reduced, further eliminating both patient discomfort and additional factors which raise medical costs.

However the greatest measure of an improved understanding between the two professions is that it may permit doctors to devote all their efforts toward healing their patients, and permit lawyers to devote all their energies to finding justice for the truly aggrieved.☐

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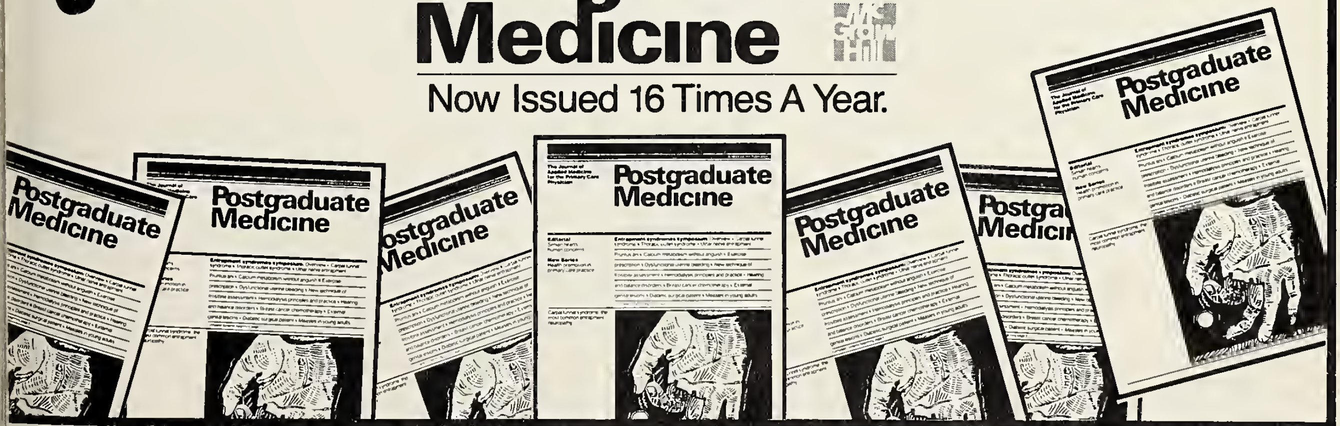


By Nancy Crandall

Auxiliary outlines its functions and goals

Mrs. Crandall, Muskegon, is MSMS/A immediate past-president.

The Michigan State Medical Society Auxiliary was founded in 1926. We currently have a membership of 2,300 physician spouses in 26 organized counties and as members-at-large. The purposes of the Auxiliary are educational and charitable and as stated in our bylaws, they are to assist in those programs of the Michigan State Medical Society that advance medicine and health education; to uphold the programs of the AMA-Auxiliary; and to coordinate and advise concerning the activities of county auxiliaries.

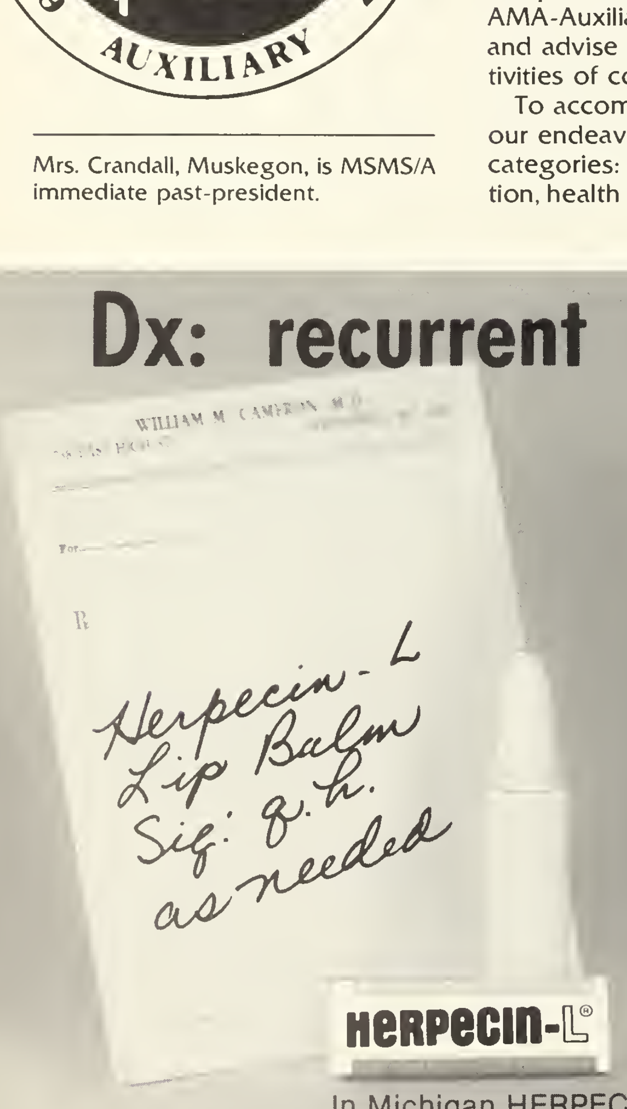
To accomplish these purposes, our endeavors fall into five categories: membership, legislation, health education, health projects, and AMA-ERF.

In the area of membership, w have much room for growth. Wit more spouses having careers, working full or part-time, and a myriad of other activities demanding time and energies, we are having to "sell" Auxiliary anc its benefits as never before. We'v placed special emphasis on spouses of medical students an residents and on those who live in unorganized counties. We are working hard to convince physician spouses, both male and female, that Auxiliary is relevant and has something to offer to each of them.

Legislative activities have bee

Continued on page 30

Dx: recurrent herpes labialis



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of prime concern to Auxilians. We now send the GRA Sheet to state officers and to every county president and legislative chairperson. Current legislative information is disseminated at county meetings and more Auxilians are becoming key contacts with their legislators.

Health education

Auxilians are active in health education in schools and the community. Our "Is He Sick?" pamphlet has gained national recognition and distribution; we sponsor Medicare Information Seminars for senior citizens; provide scholarships and loans for health related career students; do scoliosis screening and hold babysitting classes.

Our education projects include education for our own members. We assist county leaders, provide leadership training seminars, parliamentary procedure workshops, and newsletter writing workshops.

Health projects abound in every community in the state. We collect pharmaceuticals for World Medical Relief, provide infant car seats, deliver "Meals on Wheels," among other local activities. We are very involved in the Organ Donor Awareness program and share in the publication and distribution of the donor brochures and stickers. We make available to our counties an excellent film on Fetal Alcohol Syndrome, "One For My Baby," and provide information on "Bubbylonian Encounter," an excellent sexual abuse prevention program. And Auxilians around the state have been distributing the MSMS brochure on breast cancer treatment. We also participate in the National Auxiliary "Shape Up For Life" campaign, an umbrella program which promotes good nutrition, proper exercise, and stress management.

AMA-ERF efforts

As a fund-raising effort this year, we are selling tickets for a raffle which will take place at our Annual Session in May. There will be three winners, each to receive a "Grand Weekend" at the Amway Grand Hotel in Grand Rapids, the Grand Hotel on Mackinac Island, or the Grand Traverse Resort in Traverse City. The proceeds will benefit AMA-ERF and this money, along with money raised from various fundraising efforts, will be presented to the deans of the three Michigan medical schools at our convention in May.

Last May we began a year of focusing on our organization, its structure, its goals and objectives, and accomplishments. A special committee made recommendations for change, with these results: The working relationship with MSMS staff has improved, as has the relationship with Physicians Service Group. Communications, both to and from Auxiliary, are improving. The Auxiliary president is now reporting to the MSMS Board of Directors twice a year.

We want to do all we can to strengthen our relationship with the Medical Society . . .

We want to do all we can to strenthen our relationship with the Medical Society and provide the assistance that our organization was formed to give.

We have expanded the *Auxilium* format this year to eight pages full of information sent to every Michigan Auxiliary member. Our 59th Annual Session was held in Muskegon, May 6-8. This was our business session involving board meetings, reference committee hearings on a variety of issues, elections, and the installation of 1985-86 MSMS/A officers. We are honored that Mary Kay McPhee, AMA Auxiliary president-elect, was our special guest. Cathie Martin, Traverse City, was installed as MSMS/A President and newly installed MSMS President, Richard McMurray, MD, was our guest as well.☐

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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East Lansing 48823

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Samuel Kalush, MD — CDS/TS
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Continued on page 31(

A Life Is A Terrible Thing To Waste. . .

Centers for the Brain-Injured* Offer Hope

Steve was only seventeen when he s struck by a car while unloading truck at work. He spent 12 long rs in a nursing home because e was no where else for him to go. parents were unable to care for r son who was now in a wheel-ir. The Center for the Brain-Injured ovided Steve the opportunity to n to walk, live on his own, and ome employed.

John was struck by a car while riding his bicycle home from work. He spent the next nine years in various rehabilitation settings, nursing homes, and foster care facilities. His behavior made him impossible to live with. The Center for the Brain-Injured gave John the opportunity to meet his goals. Today John is able to live on his own and work at a job in his community.

Carol and her two sons were involved in a head-on automobile collision. All three sustained brain injuries. The Center for the Brain-Injured is helping Carol and her sons function as a family again.

These five lives were not wasted because help was available. The Centers for the Brain-Injured provide the opportunity for individuals who have sustained head injuries to live and work in their own community. Children and adolescents can develop the skills necessary to allow them to return to school or prepare for vocational exploration.

Tours of the Centers are available to interested health care professionals and family members of head-injured.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: May 15, A Case Study Approach to the Evaluation of Common Renal Problems: Prothuria, Hematuria, Recurrent Stones, and Recurrent Urinary Tract Infections. Location: Gilmore HEC, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Nephrology and Southwestern Michigan Area Health Education Center. **For:** All physicians. **Contact:** Southwestern Michigan Area Health Education Center, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001 (616)383-6360. **Approved for:** 3.5 hours of Category I Credit.

Date: May 16-17, Neonatal ECMO: A Seminar on Extracorporeal Membrance Oxygenation for Neonatal Respiratory Failure. Location: Ann Arbor. Sponsor: UM Medical School Department of Postgraduate Medicine and Health Professions Education and Departments of Surgery and Pediariocs and Communicable Deseases. Contact: Dove Margenau, Towsley Center, (313) 763-1400. Approved for: 10.75-18.75 hours of Category I Credit.

Date: May 17, Long-Term Prognosis In Epilepsy. Location: Kresge Auditorium, Harper-Grace Hospitals, Detroit. Sponsor: WSU School of Medicine, Department of Neurology and Epilepsy Center of Michigan. Contact: Janusz J. Zielinski, Epilepsy Center of Michigan, (313)832-0500. Approved for: 3 hours of Category I Credit.

Date: May 17-18, Neurological Update. Location: Henry Ford Hospital, Detroit. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 13 hours of Category I Credit.

Date: May 19, Home Diagnostics and Monitoring. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan Pharmacists Association Educational Center. **Contact:** MPA Educational Center, 815 N. Washington, Lansing 48906. **Approved for:** 4 hours of Category I Credit.

Date: May 20, 1985, Home Diagnostics and Monitoring. Location: Longs Convention Center, Lansing. **Sponsor:** Michigan Pharmacists Association Educational Center. Contact: MPA Educational Center, 815 N. Washington, Lansing 48906. **Approved for:** 4 hours of Category I Credit.

Date: May 20, A Tangled Web: Consideration of Brain Death. Location: Henry Ford Hospital, Detroit. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: May 20-23, Pediatrics for the Clinician: Cardiology Hematology/Oncology Infectious Diseases Rheumatology. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Dept. of Postgraduate Medicine & Health Professions Education & Dept. of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Towsley Center, (313) 763-1400. **Approved for:** 18.75 hours of Category I Credit.

Date: May 22, Health Maintenance for the Elderly: Practical Applications. Location: Grace Hospital, Detroit. **Sponsor:** Wayne State Medical School, Wayne County Medical Society and Michigan Academy of Family Physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4-H UHC, Detroit 48201. **Approved for:** 6 hours of Category I Credit.

Date: May 22, Primary Care of Hand Injuries. Location: Gilmore HEC, Kalamazoo. **Sponsors:** Hand Surgery of Southwestern Michigan & Southwestern Michigan Area Health Education Center. **Cost:** $60. **Contact:** Chris Pearson, Southwestern Michigan Area Health Education, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001, (616)383-6360. **Approved for:** hours of Category I Credit.

Date: May 30-31, Surgical Endoscopy. Location: The Towsley Center. **Sponsor:** The University of Michigan, Office of Continuing Medical Education. **Cost:** $295 Physician fee; $195 for others. **Contact:** Dove Margenau, The Office of Continuing Medical Education, The Towsley Center, Box 057, The University of Michigan Medical School, Ann Arbor 48109-0010. **Approved for:** 13 hours of Category I Credit.

Date: June 5, Fourth Annual Michigan Oral Cleft Conference. Location: Hilton Hotel, Grand Rapids. **Sponsors:** Michigan Cleft Palate Association and Southwestern Michigan Area Health Education Center. **Contact:** Janet S. Wilson, Center for Human Services, Western Michigan University, Kalamazoo 49008. **Approved for:** 5.5 hours of Category I Credit.

Date: June 6-7, Current Topics in Blood Banking: 12th Annual Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109-0010. **Approved for:** 12.25 hours of Category I Credit.

Date: June 7, Cardiology for the Pediatrician. Location: Children"s Hospital o Michigan, Detroit. **Sponsor:** Children' Hospital of Michigan. **Contact:** Continuin Education Department, Children's Hospital of Michigan, (313)494-5456. **Approved for:** 6 hours of Category I Credit.

June 12-14, Clinical Laboratory Computers: Symposium 1985. Location Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Office of Continuin Medical Education, Towsley Center, Bo 057, U-M Medical School, Ann Arbo 48109-0010. **Approved for:** 11.5 hour of Category I Credit.

Date: June 14, Geriatrics Conference Location: Michigan State Universit **Sponsor:** MUS College of Huma Medicine Department of Family Practice **Contact:** James G. O'Brien, MD, directo of clinical geriatrics, Department of Famil Practice, College of Human Medicin (517)353-0770. **Approved for:** 7 hour of Category I Credit.

Date: June 14-15, Current Topics I Ophthalmology and Symposium o Glaucoma. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospita **Contact:** Henry Ford Hospital, Continuin Medical Education, 2799 W. Grand Blvd Detroit 48202 (313)876-3073. **Approved for:** 13 hours of Category I Credit

Date: June 20-22, 35th Annual Keyport Gaylord Trauma Symposium. Location Hidden Valley Resort. **Sponsors:** Wayn State University, Department of Surger Michigan Committee on Trauma. **Contact** Theresa Sokol, Wayne State Universit Department of Surgery, 6-C UHC, 420 St. Antoine, Detroit 48201. **Approved fo** 15 hours of Category I.

Date: July 15-17, Twelfth Michiga Emergency Medicine Assembly Advances In Emergency Care. Location Grand Traverse Resort Village, Gran Traverse Village. **Sponsor:** Michigan ACEI **Contact:** Kathy Hopkins, 1305 Abbo Road, Suite 104, E. Lansing, Michigar 48823. **Approved for:** 17 hours of Category I Credit.

Date: July 25-26, Coller Penberth Thirlby Medical Conference. Location Park Place Hotel, Traverse City. **Sponso** Munson Medical Center. **Contact:** Norm Powers, Coordinator of Medical Education, Munson Medical Center, 6th Madison Sts., Traverse City 4968 (616)922-9544. **Approved for:** 9 hou of Category I Credit.

Date: August 24-27, Advances in th Management of Infectious Diseases. Location: Grand Hotel, Mackinac Islan **Sponsor:** University of Michigan Medic School. **Contact:** Office of Continuin Medical Education, Towsley Center - Bc 057, University of Michigan Medic School, Ann Arbor 48109 (313)763 1400. **Approved for:** 10 hours of Category I Credit.

Continued on page 31

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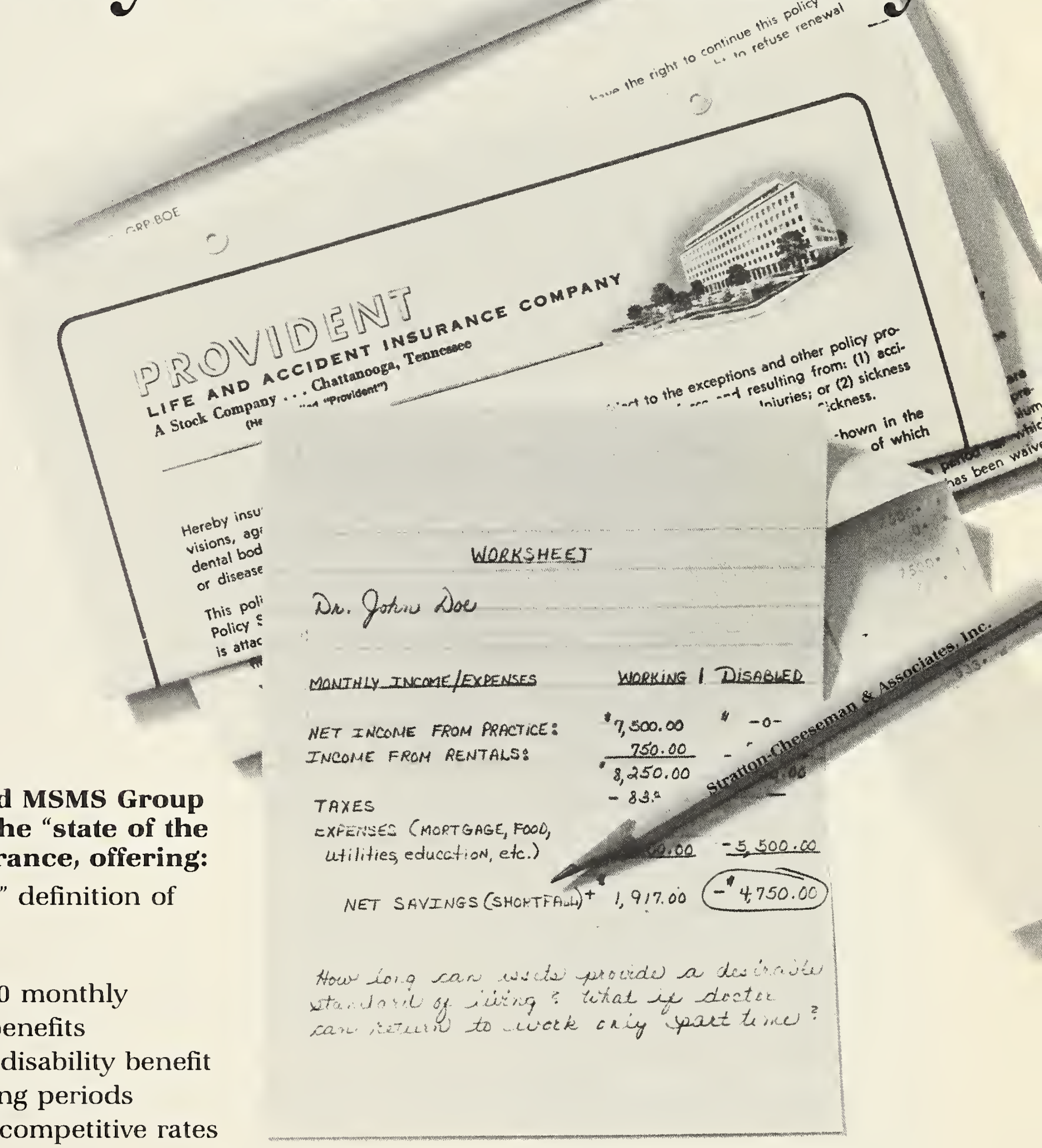
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MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

May 23-24 — MSMS Committee on Maternal and Perinatal Health Gull Lake Conference, MSU Gull Lake Conference Center, Hickory Corners, contact: Katie Brewbaker, MSMS headquarters.

June 13-17 — AMA Hospital Medical Staff Section Fifth Assembly Meeting, Chicago, contact: Dewitt C. Miner, Departme of Hospital Medical Staff Servic AMA, 535 North Dearborn Stre Chicago, Illinois 60610.

June 16-20 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSM headquarters.

CATEGORY I/Continued

Date: August 29-31, Controversies in Obstetrics and Gynecology. Location: Grand Hotel, Mackinac Island. **Sponsor:** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Washington, DC 20024. **Approved for:** 16 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Date: September 16-18, Trauma to the Hand: Diagnosis, Treatment and Functional Restoration. Location: Tows Center. **Sponsor:** American Society Surgery of the Hand. **Contact:** Americ Society for Surgery of the Hand, 30 South Parker Road, Suite 65, Aurora, 80014, (313)755-4588. **Approved f** 16.5 hours of Category I Credit.

Date: September 18, Primary C Medicine. Location: Henry Ford Hospi Detroit. **Sponsor:** Henry Ford Hospi **Contact:** Henry Ford Hospital, Continu Medical Education, 2799 W. Grand Bl Detroit 48202 (313)876-3073. **A proved for:** 6.5 hours of Category I Cre

Date: September 27-29, Eighth Ann Course in Diagnostic Ultrasound. Lo tion: Towsley Center for Continuing Me ical Education. **Sponsor:** University Michigan. **Cost:** Approx. $295. **Conta** Jolene Glaspie, The Office of Continui Medical Education, The University Michigan Medical School, Towsley Cent Box 057, Ann Arbor 48109-00 (313)763-1400. **Approved for:** 15 ho of Category I Credit.

Date: October 5,6, The Geriatrics Ch lenge / The Medical Response. Locati Holiday Inn, Petoskey. **Sponsor:** Bu Clinic. **Contact:** Kay Kelly (616)383-45 **Approved for:** 12 hours of Categor Credit.

Date: October 10-12, Henry Ford Hos tal Medical Association Alumni Reuni Location: Henry Ford Hospital, Detr **Sponsor:** Henry Ford Hospital. **Conta** Henry Ford Hospital, Continuing Medi Education, 2799 W. Grand Blvd., Detr 48202 (313)876-3073. **Approved f** 20 hours of Category I Credit.

Date: November 7-9, ACLS - Advanc Cardiac Life Support. Location: Genvie U. & Donald S. Gilmore Center for Hea Education, Kalamazoo. **Sponsors:** Br son Hospital Life Support Office & Sou western Michigan Area Health Educati Center. **Cost:** $250. **Contact:** Cy Kochevar Bouma, Bronson Metho Hospital, Life Support Office, 252 Lovell, Kalamazoo 49007 (616)3 7576. **Approved for:** 20 hours of Cate ry I Credit.

Date: November 12-14, 1985 Ann Scientific Meeting. Location: Hyatt gency, Dearborn. **Sponsor:** Michi State Medical Society. **Contact:** Sherr Fent, MSMS headquarters. 18 Catego Credits applied for.

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ly 18-20 — MSMS Board of rectors Midsummer Meeting, dden Valley Resort, Gaylord, ntact: William Madigan, MSMS adquarters.

ctober 17-19 — AMA National edical Staff Conference, Shera- n Washington Hotel, Washin- n, DC, contact: Karen Prupes, 12) 645-4418.

THER MEETINGS

y 15 — Michigan Allergy So- ty Executive Committee Meet- , University of Michigan, con- t: David Seaman, MD, Secre- y, Michigan Allergy Society, 78 Canton Center Road, Can- 48187 (313) 453-2661.

y 17-19 — Michigan Associ- on for Medical Education An- l Meeting, Hilton Shanty eek, Bellaire, contact: Viola M. ins, MSMS headquarters.

y 17-19 — Michigan Society Pathologists Scientific Meet- s, Hyatt Regency, Flint, contact: Viola M. Heins, MSMS headquarters.

June 6 — 1985 Annual Meeting of the Greater Detroit Area Health Council, Incorporated, The Westin Hotel, Detroit, contact: Symond Gottlieb (313) 963-4990.

July 24 — Michigan Psychiatric Society Council Meeting, Inn on the Park, Toronto, contact: Michigan Psychiatric Society, 21700 Northwestern Highway, Suite 1175, Southfield 48075.

August 2-4 — Summer Seminar of Michigan Medical Assistant Journal, Hyatt Regency, Flint, contact: Michigan Medical Assistant Journal, 6724 Cooper, Lansing 48910.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313) 839-3011.

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By Richard J. McMurray, M

We have a responsibility to lead

I feel very honored to have been selected to the presidency of MSMS. I sincerely plan to justify the confidence that has been given me.

I would be remiss if I did not at this time thank Lou Zako publicly for the tremendous time and effort he put forth this past year on behalf of MSMS. I am most happy to inform you that Doctor Zako will continue to spearhead the ad hoc committee on medical liability which he so aptly chaired this past year. Several new initiatives need nurturing and guidance in order to put into place a working plan which we anticipate will allow physicians to practice good medicine without feeling there's a loaded gun at their heads, and yet give our patients a certain security for financial relief if and when a physician's obvious negligence does occur. If this does not come to fruition, affordability and availability will become one and the same. The loser will ultimately be the injured patient.

I expect my theme this year will be the words we have been hearing the last several months: "change" and "opportunities." It is my firm belief it is up to physicians to seize the opportunity that change presents to mold medical care delivery into a cost effective, beneficial system for our patients, yet still maintain the highest quality of care and the personal physician-patient relationship so important in the healing art. There is no question that there will be interference from outside forces which will

make this difficult. We necessarily will have to readjust our practice habits—we may even have to start being clinicians again and not merely technicians sorting out high tech medicine.

The high cost of medicine has become the whipping boy. Affordability of medical practice has now become the concern of patients, retirees, unions, hospitals, large corporations, and yes, government, as well as of physicians. I submit that all of these entities must accept their fair share of the responsibility for the cost of medicine which we now say we cannot afford.

Our responsibility should be to lead—let us show the other agencies we are serious when we say we want to maintain high quality care at an affordable cost. Acquaint yourself with the cost containment check list.

But how about the responsiblity of our patients? Diet, smoking, and alcohol are detrimental to health—have our patients made a commitment to change?

Trimming the budget

First dollar coverage for all illness or perceived illness has been the thrust of the unions these many years. Education in health care and needs might be more cost effective, especially with a substantial co-pay as a coercive factor. Obviously the day of cos plus contracts for hospitals is drawn to an end. I expect that cost shifting also will be very limited, if not eliminated, which wil lead to a lean, prospective type budget. *Let us as physicians mak sure that trimming the budget i not done at the expense of direc patient care.*

The large corporations always have passed health care costs d rectly to the consumer. The burden of that cost has now cause consumer rejection of the high cost of American made products—corporations will need to bargain tougher and educate their union adversaries in first do lar coverage and health needs. The AMA told the government back in 1966 that it could not a ford the Medicare package.

Life itself is a terminal disease We have not made the progres we should have in promoting wellness, but we have become very good in prolonging death. Technological immortality has be come a fiscal unreality, i.e., the amount of medical dollars spen in the last three months of life.

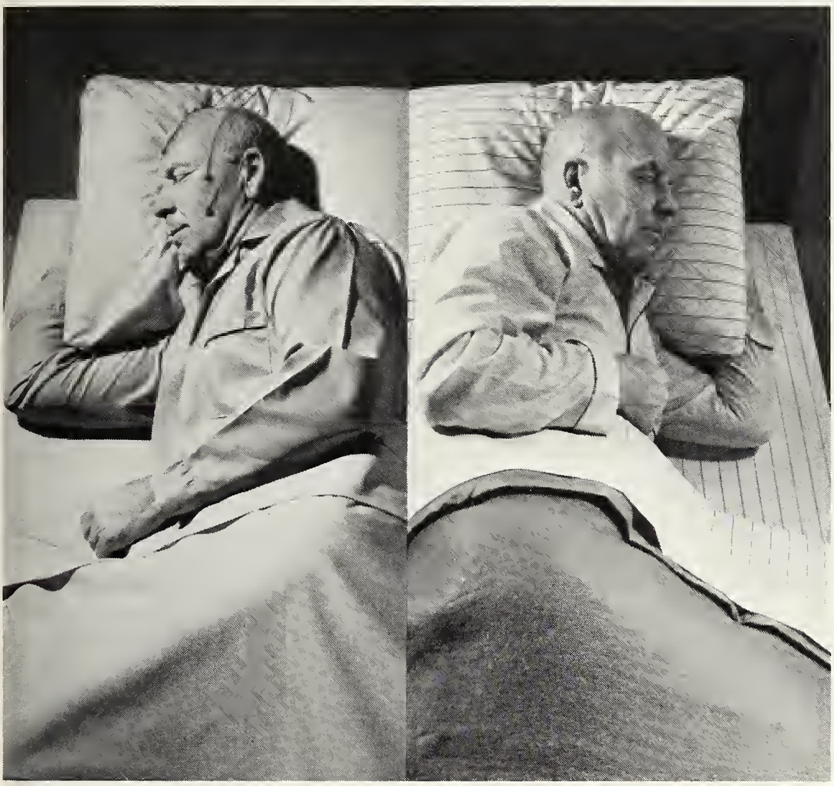
The AMA has spent the last 1 20 months diligently promotin and developing a national Heal Policy Agenda (by committees made up of all the aforementioned groups). Out of this, pri ciples and guidelines will set th stage for long term solutions t many health care problems.

Until this is in place it will be physicians' responsibility to provide the necessary leadership t maintain the high quality of car in an affordable fashion.

I challenge all physicians to a cept this responsibility.☐

This is the first of a year-long series of columns by MSMS President Richard J. McMurray, MD, Flint obstetrician/gynecologist.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



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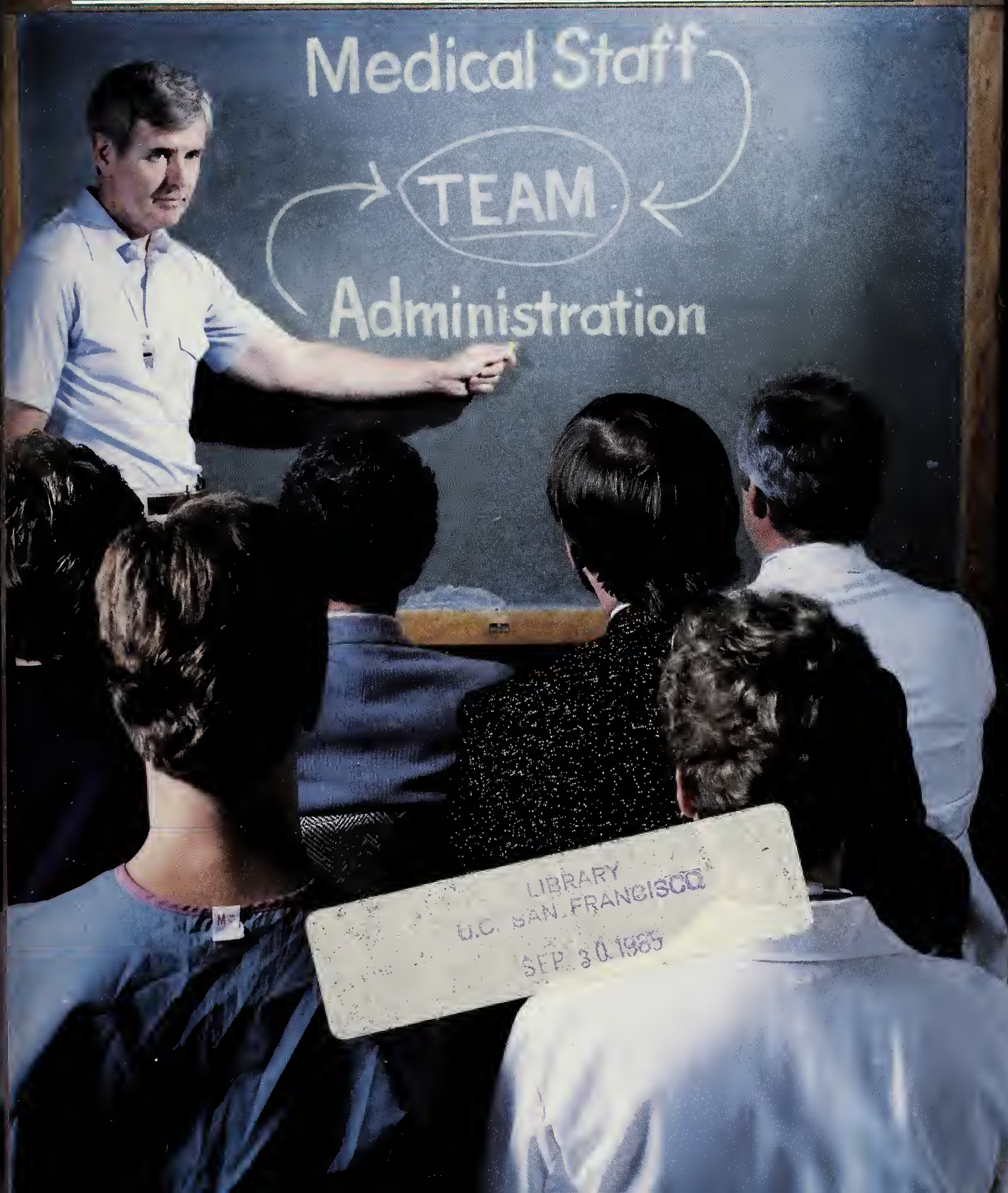
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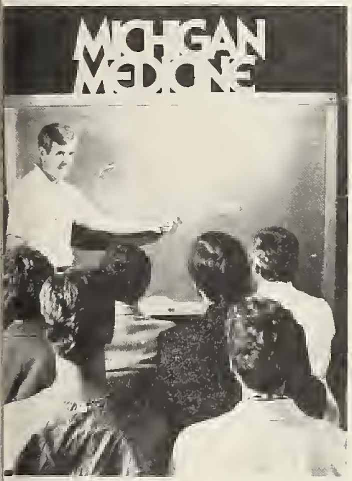

bout the cover:
he goal of the new MSMS
ospital Medical Staff Section is
o bring the two teams — ad-
ninistrators and physicians —
ogether to work toward a win/
vin situation.

n next month's Issue of *Michi-*
an Medicine: Another in-depth
eport on MSMS initiatives to re-
olve the professional liability
risis.

Special report

322 Improved communication between hospital administrations and medical staffs is the first thing the MSMS Hospital Medical Staff Section hopes to accomplish. Then it can get down to the business of ironing out specific wrinkles in administration/medical staff relationships. This month's special report features an interview with Peter A. Duhamel, MD, first chairman of the new section; photos of the first meeting of the HMSS; the unique perspective of Jack Ryan, MD, administrator and physician; legal counsel's insight into the issues; and an interview with new Michigan Hospital Association head Spencer Johnson; Carole Eberly; Monte Jahnke, JD; Judy Marr.

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IN MY OPINION

By Leland E. Holly, MD

The best buy—a cooperative effort

All pressures on the health care system appear negative to you and me. Financial pressures encourage cost control and price competition, not delivery system expansion and better access like before. Worse, only lip service is given to maintaining or improving the quality of health care.

The reactions of government, industrial and public groups to burgeoning health care costs is understandable and the collective message we read from them is, "Not one penny more should be spent on health care."

That is patently unrealistic. It is generally agreed that, short of more severe cutting and rationing of services than now implicit in programs proposed and implemented, the total cost of health care delivery will continue to rise. (Some say to about 12 percent of the GNP.)

What the payor message should be, and perceived by us to be is, "We want a better, in fact the best possible, health care buy for our dollar."

For many reasons, up to now payors have not gotten the best health care for their buck. (Some current programs continue to deny them good value.) Not all of the problem lies with us but we should be able to do something positive in those areas for which we are responsible.

This is not a negative pressure. This is a challenge.

Physicians must move, with hospitals and others, to integrated health care delivery systems. The strongest systems would be cooperative ventures combining each venturer in a compatible, responsible, financial, administrative and medical manner (e.g. Mayo Clinic). Perceived control of costs and quality would assure the payor (ultimately the patient) of the "best buy."

The bottom line is that we sorely need cooperation and understanding between physicians and hospitals. Each must contribute their special skills and knowledge in spite of the many forces that now push them apart. The hospitals have too many beds and antiquated financial structures and philosophies. There are too many doctors with loose quality controls and poor administrative and people skills.

What is salvageable for the future of hospitals and physicians lies in a committment to enlightened cooperation.

I'm glad MSMS has its hospital staff section underway. MSMS can now match the Michigan Hospital Association at each level. The stage is set to begin meeting the challenge together to offer the payor (ultimately the patient) the best health care buy for the dollar.☐

Doctor Holly, Muskegon radiologist, is MSMS treasurer and member of the Committee on Publications.

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Patient's family praises skillful surgeon

The following upbeat letter, mailed to Sister Mary Ellen Howard, administrator of Mercy Hospital in Grayling, is typical of letters received by physicians every day. This one, praising K. Ramaswamy, MD, and R. Steffe, MD, happened to come to MSMS, so the editors decided to share some "good news" with the membership:

Let this communication express both my professional respect and personal gratitude for he expert medical emergency reatment and follow-up care which your hospital provided my wife, Thelma Bast, beginning November 23, 1984.

There is no doubt that the rapid and skillful emergency surgery of Doctor K. Ramaswamy saved her life, leg, and all her organic brain functions. My family and I are deeply grateful for the uperior medical leadership of Doctor Ramaswamy and the ooperative efforts of Doctor R. Steffe. We are extremely appreciative of your Nursing Staff which extended from the Emergency Room through surgery and through the long hours of continuous effort in the Critical Care Unit, as they continued to reverse a deteriorating, near-fatal circumstance. Through those efforts Thelma soon became able to appreciate the excellent care of the Surgical Nursing staff until discharge.

All of us remain immeasureably grateful for the strength and spiritual care consistently provided by the Chaplain's Corps through our most painful hours.

Thelma remains very appreciative for the continued concerns of the Dietary and Housekeeping staff personnel who were extremely solicitous throughout her hospitalization.

I am pleased to inform you that Thelma has continued to recover in remarkable fashion following Doctor Ramaswamy's transfer of her care to this Medical Center. As of this date she is discharged from all medical follow-up.

Meanwhile, Thelma and each of us remain equally grateful for the unparallelled care provided by your medical facility. Measures are now being taken to name Mercy Hospital, Grayling, as a benefactor in our future affairs.

Bernard A. Bast, PhD
Detroit

By Judy Marr, Editor

Improved communication the goal of MSMS Hospital Medical Staff Section

Doctor Duhamel

It was an unseasonably warm April afternoon when Peter A. Duhamel, MD, strode into his ground floor office in the Rochester business district.

"I'm sorry to be late," he apologized. "I had to spend some extra time with a patient this afternoon. She's 23, married with no children, and we discovered possible breast cancer.

"It was not an easy job to talk with her. She's the youngest patient I've had with the disease."

Even as the discussion moved to the subject of hospital medical staffs, it was clear the robust general surgeon's thoughts were still with that patient.

First-hand experience

Doctor Duhamel is one of 75 surgeons affiliated with Crittenton Hospital in Rochester, a 300-bed, private, non-profit community facility. There are 150 active medical staff members and approximately 100 on the courtesy staff.

Doctor Duhamel is past vice chief of surgery and past chief of staff there. While chief of staff in 1978-1980, he served on the hospital board and gained some first-hand experience with the problems of hospital administration.

From experience, Doctor Duhamel observed wryly, the problems of administration "are not always appreciated by the doctors on the medical staff."

Doctor Duhamel has been active on medical staff committees and has served on the hospital's surgical quality care review committees.

Because of that experience, he was elected two years ago to represent his Crittenton medical colleagues in the initial meetings of the AMA Hospital Staff Section. And he also has been key in the formation of the MSMS Hospital Medical Staff Section, serving as its first chairman. Doctor Duhamel was elected at the March organizational meeting of the MSMS section.

"The medical staff at Crittenton has had a very good relationship with the administration that could be communicated to staffs at other hospitals through the HMSS," he observed. "In the same light, we can get communication from other hospitals about similar experiences they might have had that would be of help to us."

Communication is key

Despite Crittenton's good history, he notes that at times some medical staff members have felt they have not had enough input. Those planning new facilities have sometimes been more interested in architecture than in the hospital's medical needs, he said.

Improving communications between hospital administrations and staffs is the prime reason fo the Hospital Medical Staff Section, he said, and it is his first priority as HMSS chairman.

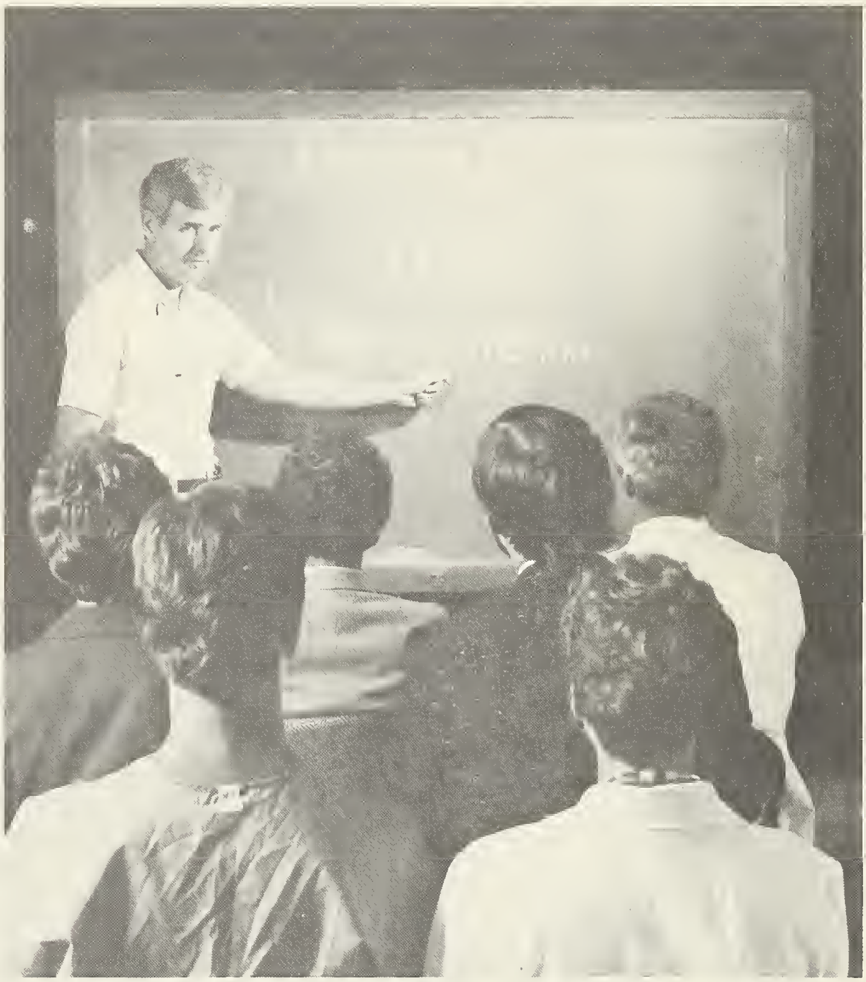
He also sees need for hospital medical staff organization in light of "considerably less money coming in to the hospital which is going to be available for medica staff purposes.

"As a result, the medical staff may have to fund some things themselves," he said.

He also believes the medical staff has to be "more than cooperative—almost in partnership" with the hospital because of the new DRG requirements.

"Soon we will have DRGs for doctors' services, and there will have to be a division of funds between hospitals and physicians."

He considers his liaison with the AMA Hospital Medical Staff Section to be his top consideration, and he underscored the importance of communication from national to state to county



organizations, and then to the local representative.

"The local hospital representative must be highly visible on the staff, there every day and available for people to talk to informally," he emphasized. "He or she has to find out if there are problems and then bring them to the organizations involved."

The local representative must either be a member of the medical executive committee in the hospital or have regular access to it, he continued. He or she also should commmunicate regularly on a formal basis with the staff. Options for such action can include speaking at quarterly medical staff meetings and distributing a newsletter.

Over 50 percent of eligible (JCAH certified) Michigan hospitals have appointed or elected representatives to the MSMS Hospital Medical Staff Section, reported Doctor Duhamel.

"It would be better for the hospitals if we had 100 percent participation," he said. "We could share information better if we had hospitals of all sizes and types—teaching, university, community, proprietary, big and small—involved.

"All types of hospitals share the same problems and solutions."

More education

A second priority for Doctor Duhamel is presenting more programs for physicians like the recent MSMS conferences on contracting and joint venturing. He'd like to see programs on malpractice, mandatory insurance coverage, and medical services by alternative health care professionals.

"Up to now each hospital has dealt with these problems on its own, without much support or guidance," he said. "Many states are far ahead of us in the field, and we can come up with some recommendations for individual staffs."

Doctor Duhamel said he would personally like to impress on every physician involved in utilization review concern for the care every patient receives, and not just the bottom line of dollars and cents.

"The HMSS will deal with the current crunch on cost containment," he said firmly. "We have a strong commitment as physicians to the quality of medical care, and all we hear about is utilization review.

"The quality of care cannot be sacrificed because of cost constraints."

He spoke of the suspension of physicians for "over-utilization:" "This frequently is a summary suspension with no opportunity for the physician to answer charges and no opportunity for any medical staff committees to intervene with any of its committees. Each physician must be entitled to due process.

Continued on page 324

"If the United States is in such terrible financial straits that it is interested only in cost and not in quality, perhaps we should consider practicing as they do in some other countries where they have socialized medicine! This would lead to rationing of medical care or a two- or three-tiered system of medical care," he warned.

Delegates' resolution

As Doctor Duhamel was interviewed he anticipated the outcome of a resolution before the MSMS House of Delegates calling for MSMS to establish a joint committee with the Michigan Hospital Association to resolve physicians' disputes with their hospital staffs. That resolution was approved with amendments.

Delegates at the first MSMS HMSS meeting in March drafted the resolution. The idea originated at the national level.

"We think it is very worthwhile to communicate through the parent organizations, to set up joint committees on a local, county level, to try to help out in situations where there may be discord."

The major project of the MSMS HMSS this year is to become more solidly organized, with all eligible hospitals sending representatives to the 1986 Hospital Medical Staff Section meeting next March.

Doctor Duhamel also would like HMSS to organize a statewide meeting for all physicians to discuss malpractice or the admission of non-fully-licensed practitioners to medical staffs.

The MSMS Board has given the HMSS the task of analyzing the quality review objectives of the Michigan Peer Review Organization and reporting back to the Board with recommendations.

"I would think that approximately 90 percent of doctors in Michigan practice on hospital medical staffs. Our organization should be of interest and importance to all of these doctors.

"I anticipate we will function as an increasingly important section of the MSMS," he said. "We would like to become the official MSMS arm in relations with the Michigan Hospital Association and any other situations involving hospital medical staffs."☐

MICHIGAN STATE MEDICAL SOCIETY
18 66

MSMS President Richard J. McMurray, MD, left, shares a lighter moment at the first MSMS Hospital Medical Staff Section meeting with fellow Flint physician George Greidinger, MD, of St. Joseph Hospital.

Scenes from the initial MSMS Hospital Medical Staff Section meeting . . .

homas Peebles, MD, right, chairman, merican Medical Association, Hospital edical Staff Section, addressed the group, hich met March 11 at the Michigan Inn, outhfield. Doctor Peebles discussed "Hospital-Physician Relations in a Dynamic nvironment." Other speakers included Louis . Zako, MD, MSMS immediate past president, ho described the importance of the HMSS o organized medicine; Gary D. Maynard, MD, hairman, MSMS Medical Staff Relations ommittee who outlined the order of usiness; and Peter A. Duhamel, MD, rittenton Hospital, who was elected hairman of the HMSS during the session.

etworking, while not on the agenda, was an essential function of the HMSS meeting. Sharing information above, om left to right, are Dewitt Miner, AMA department director, Medical Staff Services; Robert D. Allaben, MD, Detroit, ichigan delegate to the AMA; guest speaker Thomas Peebles, MD; and Peter A. Duhamel, MD, MSMS HMSS chairan.

One MD's unique insight into hospital/physician relationships:

All of the issues ultimately boil down to one: economics. Physicians today are justifiably frightened . . . . On the same plane, hospitals are frightened. . . .

Doctor Ryan

Jack Ryan, MD, Detroit, is much in demand these days for his views on physicians and hospitals because he has a unique perspective. A practicing physician for over 20 years, he has served as president of a 21-physician multi-specialty group. For two years he has juggled dual careers as physician and vice president of medical affairs for the Detroit-Macomb Hospital Corporation. He has been the corporation's president since 1977, and is overseeing the building of a new 300-bed hospital to replace the Alexander Blain Memorial, Jennings Memorial and Detroit Memorial hospital facilities.

Because of his uncommon wealth of experience, *Michigan Medicine* sought Doctor Ryan's views for this special report on the physician/hospital relationship.

Q: What are the main issues facing hospitals and physicians today?

A: All of the issues ultimately boil down to one: economics. Physicians today are justifiably frightened. Their practices are down, and their incomes are down. On the same plane, hospitals are frightened with the new reimbursement mechanisms, with DRGs, and their impact on the patient census.

Historically, hospitals were institutions which supplied the bricks, mortar, beds and equipment. Physicians supplied the patients and ordered what they wanted. They kept patients in the hospitals as long as they wished.

With the imposition of DRGs, hospitals are going to have to become more concerned with the physician who orders every test, who lets Aunt Nellie stay an extra two days because it's easier on the family.

That's the groundwork for clash.

Today, we also are seeing some hospitals move into the practice of medicine, through establishment of ambulatory care centers, medical clinics and surgicenters. They act as direct competitors to their own medical staffs.

The obverse side of the coin is that physicians are developing centers which are competitive with hospitals.

Q: How do you anticipate hospitals will cope?

A: I see hospitals moving in the direction of tighter control of medical staffs, especially in policy determinations not strictly related to medical practice.

We will see a significant reduction in numbers of hospitals. We are going to see mergers and closings and more multi-hospital systems, with hospitals fewer but larger.

Q: Do you think this decrease

By Judy Marr, Editor

n numbers of hospitals will afect the quality of care?
: I don't think the mere fact that small hospital merges with a arger hospital, or closes, has any mpact on quality. It could coneivably have an impact on the vailability of care.

: How do you assess the imact of the satellite clinics upon he practice of medicine?
: I would envision that more hysicians will become salaried nd will work in that type of enironment. I want to make it perectly clear that's not necessarily hat I *want* to see. That's what I hink is going to happen.

We have far more salaried hysicians today than 10 years go, for many reasons. Among hem is the increase in female hysicians who may want to ombine practice with a family, nd find it convenient to work set ours. Presently-graduating edical students don't hold the ee-for-service concept as holy s did students of the past. In ddition, salaries are becoming ompetitive with what one can ake in private practice, and here are the projections of a hysician glut.

: What do you think of the preicted physician surplus?
: I'm not convinced there will e a glut of *outstanding* physiians.

: How can physicians and ospitals cooperate?
: The biggest single element for ooperation is physicians serving n hospital boards and commitees. Hospitals must organize to et physician input at all policy vels.

Both have to try to understand e other's problems and recogize their dependence on one nother.

: What do you think of the new SMS Hospital Medical Staff ection?
: That depends on the direction takes. If its goal is to achieve logical cooperation, and to determine that intelligent people can agree to disagree, then it has some merit.

The main thing on its agenda should be to explore areas where physicians and hospitals can work together to create win/win situations.

Q: What do you think will be the impact of the new JCAH recommendation which states that medical staffs are responsible for creating their own bylaws, rules and regulations?
A: In Michigan, total authority for the hospital is vested in the hospital board. Whatever autonomy a medical staff has is that which is delegated to it by the board, the JCAH notwithstanding. The JCAH recommendations are just that. I don't think they constitute any significant change.

Q: How do you think recent cost containment efforts affect the practice of medicine?
A: I'm not aware of any regulation in health care in the last decade which has curtailed costs. Most have only increased costs because of the additional paperwork and bureaucrats required to administer them.

My biggest concern with DRGs is that they could have an effect upon quality of care. I'm just waiting for the first DRG-related malpractice suit based on an allegation that a patient was discharged too soon, or that a test was not ordered to save costs. I think it's only a matter of time.

As for other cost containment programs, I don't see them accomplishing anything, because they don't get at the real problem.

A recent Kellogg Foundation study found the top three causes of health care costs are increased demand, growing numbers of elderly persons and high technology. We really don't have a great deal of control over any of those.

None of the so-called cost containment measures so far addresses the matter of demand. As far as I'm concerned the only way we're going to have an effect upon demand is for the patient to be responsible for some portion of his costs.

Q: Do you have any suggestions for health care cost containment?
A: We could have a catastrophic insurance program in which each person would be responsible for contributing X percent of his pretax income, up to a certain percentage. The indigent could be taken care of either out of that program or out of tax revenues.

You wouldn't develop a two tier system of health care, and the patient would not run to the hospital emergency room whenever he had a cold, because he would have to pay $10 per visit.

I don't know of any other human need that is completely covered without the individual having any responsibility.

Can you imagine what would happen if food was free? There would be no more macaroni and peanut butter. It would be all filet and caviar. That is what is happening in health care. They've given benefits away, and now they can't take them back.

Q: How about the physician/hospital relationship and the current malpractice insurance crisis?
A: There is no question that all hospitals in the state will require physicians to have malpractice insurance coverage, because they have to. Even if hospitals opted not to, I think their insurers shortly would require them to. It will be a prerequisite for hospitals to obtain insurance.

I would like to see something formed where hospitals and medical staffs could be covered under the same insurance carrier.☐

By Monte D. Jahnke, JD

Future-shock and the medical staff

Pervasive changes in medical reimbursement and delivery have left virtually no area of physician professional life untouched. This is perhaps no more apparent than in those issue areas surrounding physician relationships with medical staffs and overall staff relationships with hospitals.

The traditional attitudes of "peaceful coexistence" and "friendly tolerance" characteristic of governing board/medical staff dealings are rapidly giving way. New forces generated by cost-conscious management, overbedded hospital catchment areas, an overabundance of physicians, and widening diversification of medical benefit plans are now at play. Whatever the results, it is clear that former medical staff and hospital operations may prove unresponsive to the demands emerging statewide. The halcyon days are gone ... well, maybe.

I say maybe because the present atmosphere is not only one of rapid transition but also one of long-range opportunity. Medical staffs should reexamine their structure and how their hospitals are run. They must begin or greatly enhance management and planning communications with hospital administrators. The alternative, in my view, is a loss of medical staff discretion and perhaps the first step toward evolution of the medical profession into a mere skilled trade. The discussion below briefly reviews the main issues compelling new direction for medical staffs and their leadership.

The main issues

Michigan law creates pervasive governing body rights and responsibilities for virtually all phases of hospital operation, including ultimate responsibility for the choice of medical staff members. The traditional practice of delegating many duties to the medical staff has worked successfully for a long time. Similarly, hospitals accustomed to more liberal traditional reimbursement systems based on units of service and the recapture of costs often did not observe budgeting and management techniques comparable to affairs in private enterprise. Recent economic and competitive changes have forced hospitals to be more cost-conscious, and along with budgeting and other management techniques, many hospital administrators are focusing on closer monitoring and management of medical staff affairs.

This emerging trend has led to efforts by some Michigan hospitals to have a closer influence on the choice of medical staff leadership and their terms of office. It has heightened attention to medical staff accountability in light of prospective payment and the cost driven/incentive based reimbursement plans now impacting institutions through hospital networks, HMOs, and PPO (PPA) arrangements.

At the same time, the Joint Commission on the Accreditation of Hospitals (JCAH) has reexamined its entire set of standards for medical staff accreditation. Specific standards have changed in four general areas: medical staff composition; encouragement of more specific localized mechanisms for granting privileges and reappointment accountability to the hospital governing body, and increased power for the medical staff leadership. The history and scope of the 1984-85 JCAH changes is a topic well beyond the intent o this article. The important point to remember is that the changes have occurred coincidentally with fundamental changes in competitive factors surrounding health care delivery. This should advance the overall pace of change.

Other important issues concern medical management, cost incentives, the quality of patient care, and the scope of privileges Prospective payment by DRGs, for instance, makes it imperative that each hospital track physician and departmental behavior on a cost accounting basis. Many Michigan hospitals are implementing elaborate computerized cost tracking programs that will allow hospital administrators to compare physician to physician and department to department profit and loss behavior under DRGs.

Increasing use of prospective payment concepts by the private sector makes cost effective behavior under such a program imperative for all hospitals and medical staffs. For example, Blue Cross/Blue Shield of Kansas adopted a prospective payment based reimbursement system as of January 1, 1984, and several other large insurance companies as well as Michigan Medicaid, ar examining or implementing the

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Mr. Jahnke is an attorney with Kerr, Russell, and Weber, Detroit, MSMS legal counsel.

Cost effective primary and specialty physicians who can help an institution survive or make money could be at a premium.

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ost scrutiny results

The result of such close cost
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dministrators and medical staff
eaders will not only have to grap-
le with the traditional accredi-
ation issues of training, experi-
nce, and good moral character,
ut will also seek evidence of a
hysician's actual or potential
ost effectiveness before decid-
g to grant privileges. This could
ad to a reduction in certain
rivileges for existing staff mem-
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rivileges for new members,
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ore salaried physicians, and
erhaps even the curtailment or
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veen hospitals in a geographic
ea or within a particular hospital
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n appropriate role

The appropriate role of the
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obably the most challenging
sue facing physicians today. It
lls for a level of accountability
d performance which is fraught
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sue implications.

Many hospitals caught up in
e contemporary version of
urvival sweepstakes" are reor-
nizing or pursuing affiliations
hich, as recently as twelve
onths ago, were of no interest
many of them. Competition
ain is the stimulus; the goals
e to preserve patient markets,
netrate new markets, and to
quire the capital necessary to
do so. Reorganization making the hospital entity a subsidiary of a holding company which has potential for profit subsidiaries and lines of business is a favorite technique. New affiliation efforts often include contractual relations with other hospitals in a geographic area to enhance marketing and patient distribution patterns, or joint ventures with some or all members of a medical staff or staffs.

Too often, hospital governing bodies appear to have taken fundamental steps toward these types of projects without adequate early involvement of medical staffs. It may be the unfortunate view of some hospital governing bodies and their administrators that what they choose to do with and for the hospital is none of the physicians' business, or that physicians with privileges at several institutions can't be trusted with business planning information. On the other hand, there is a fair amount of physician apathy in many quarters. Physicians comfortable with practice patterns, life style, and hospital affiliations seem sometimes to be hoping that the issues will go away if ignored. Neither side in such an atmosphere of contrived or even benign neglect will succeed. Early dialogue and cooperation must occur.

New hats for both sides

Those more enlightened medical staffs and administrators are communicating and, to the extent possible, planning jointly for the future of a given hospital or hospitals. Just as administrators today are beginning to wear new hats as business managers, medical staffs attuned to current trends are appreciating the need to care, understand, and act upon issues vital to the future of the hospitals with which they are affiliated.

Clearly, a new dimension must be added to the mission statement of any medical staff. Physician leadership should seek and analyze information from hospital administrators and governing bodies and should recognize the proprietary sensitivity of any information shared. All of this may lead to a closer allegiance between previously independent practicing physicians and a single hospital; the multiple medical staff affiliation pattern pursued by many physicians may become an economic anachronism.

The foregoing are tough issues and suggestions to be sure. They probably raise unfortunate images and emotions in the minds of most physicians. They are, however, matters of reality which must be faced. Medical staffs are acquiring the skill and assistance to do so and must enhance their capabilities in this regard. The American Medical Association Hospital Medical Staff Section recently endorsed the concept of separate counsel for a medical staff, and one might perceive other types of professional consultants to assist a given medical staff in its evaluation of emerging trends.

Future-shock is manageable provided that a medical staff and its leadership are attentive and diligent in their efforts. There are legal and practical pitfalls but the forces of health care competition which cause these changes demand a response and therefore present significant opportunities. I once again here endorse the gospel of opportunity rather than avoidance.☐

SPECIAL REPORT

By Carole Eberly

New MHA director calls changes a response to homogenized society

Sweeping changes in the medical field, including changes in the medical care delivery structure and a decrease in independent medical practices, were predicted by Spencer Johnson, the new director of the Michigan Hospital Association.

In a recent interview, Johnson said the day is not far off when physicians will be working for medical care delivery corporations instead of themselves. He ticked off a list of reasons, including "our homogenized society."

"When you pick up the Sunday paper and the prices are the same in Sears in San Francisco and in a shopping mall in Lansing, this is a homogenized society," he said. "And malls seem to be the standard. It's mass marketing. It's mass behavior."

In that context he said while people are interested in a relationship with an individual physician, "by in large, they are interested in some homogenized things first — quick access in location and hours, reasonable prices, a lot of things covered for the money."

A mission to renew

Johnson sees his mission as the renewal of Michigan hospitals in terms of capital, physician relationships, insurance coverage and delivery of health care.

"We're heavily invested," he said. "We are the General Motors of the health care industry. The plants are there, the bricks and mortar, that's where the resources are invested.

He said if hospitals are to keep pace with the changing health scene, there has to be some redefinition of what a hospital is. Although the traditional hospital will not entirely go away, he said some will become vendors of their services to physicians in private practice or government agencies while others may become part of multi-state or national system.

"People say that hospitals should be operated like a business," he said. "The truth is, while we can talk about in terms of business concepts, we as an industry are still left with several public policy challenges that normal businesses are not left with."

"No matter how businesslike we behave, we still have to meet the needs of the indigent and aged," he said.

Johnson said physicians also have a stake in the renewal theme and public policy challenges.

"Certainly we see them active in quality issues, medical malpractice, medical education and ethical issues," he said. "But when it comes home to the facility, we can all philosophize and conceptualize about them in terms of public policy, but many of these issues are coming home at the facility and will have to be dealt with."

Johnson viewed the MHA's role as one of leadership in facing these issues.

"It's important to be a convener around these issues," he said. "That is to talk about them before they become a crisis, to lay the issue on the table in the public arena, to advance our thoughts about ways to cope with issues, to get input from others and involve others in their solutions."

He said both short-term issues like medical malpractice and longer-terms ones such as the changing picture of health care delivery calls for cooperation between the MHA and the MSMS

"As we get through the malpractice issue in terms of curren events and we engage some o these other issues in advance, those working relationships (between the MHA and MSMS) wi cement themselves," he predicted.

A closer relationship

He foresaw on the horizon a closer relationship in the interest of physicians and hospitals through the payment mechanis because of the "unbundling of services" that has occurred in th last ten years.

"That is a separate bill for the anaethesiologist, radiologist and so on," he said. "And that mean the physician and the hospital ar going to have a very close interest in terms of the economic production of health care in tha facility. They will have to be competitive against the standar of payment from the third party payors and against the other activities of institutions and physicians in their region."

The MHA's role in individual hospital issues such as staffing and bylaws is one of hands-off because of the diversity involved Johnson said.

He didn't think bylaws could be written without the participation of physicians "as well as we have to recognize it is the responsibility of the facility, trustee and administration. Certainly yo need the participation and concurrence of the physicians."

The MHA director, who move to Michigan after holding a simila position in New York, believes Michigan has it all over New Yor in being able to handle the changing medical scene.

"There are many challenges ahead for many hospitals and physicians, but fortunately there are many resources in Michigan by which to respond and I think there are innovative people here he added.☐

Ms. Eberly is a Lansing-area freelance writer.

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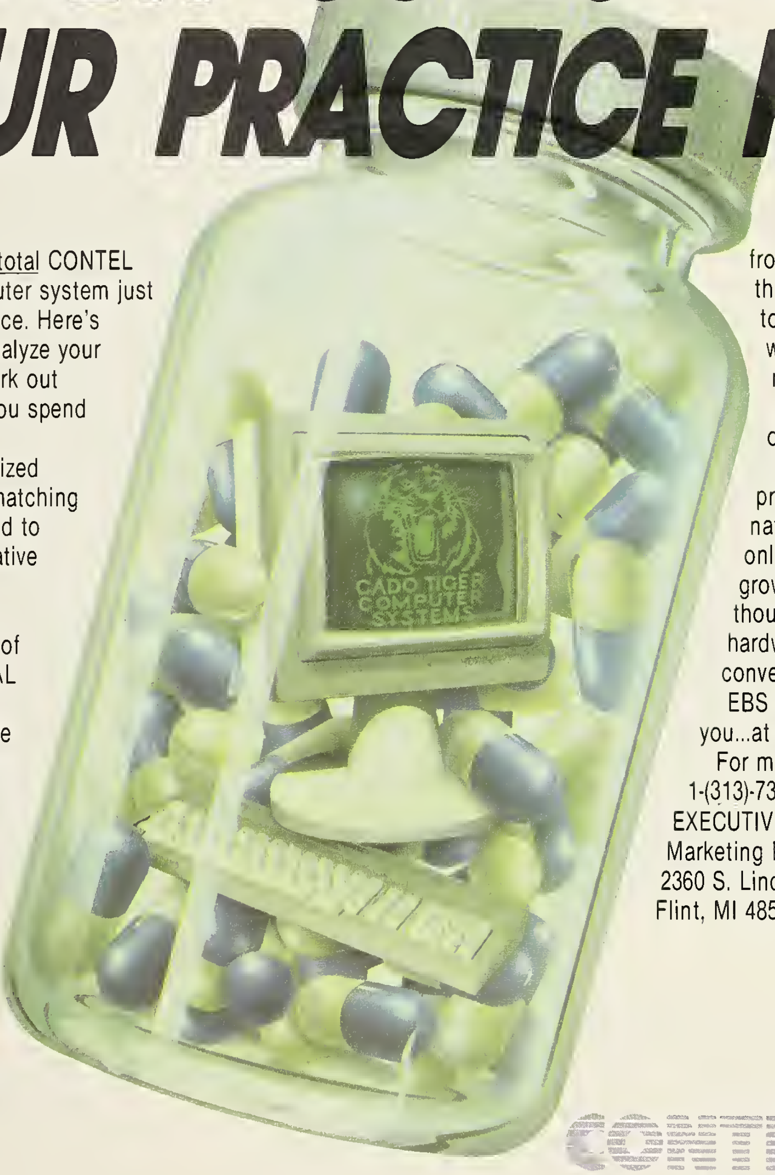

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Three MDs discuss DRGs and the changing practice climate

Kenneth B. Herrington, MD
Bad Axe

The DRG system of cost containment went into effect in the "thumb" area approximately one and a half years ago. This, along with other cost containment measures, has had a profound effect on the method and delivery of care in the area. It has shifted a great deal of inpatient care to outpatient care.

At Huron Memorial Hospital for example, there has been a drop on inpatient census of 16 percent during 1983-84. During the first six months of our fiscal year (since October, 1984) there has been 13 percent drop in census days as compared to the first six months of fiscal '83-84. During this same period, outpatient surgeries have increased 15 percent with outpatient encounters increasing 8-9 percent. It is interesting to note that emergency room visits have remained the same during this period.

Thus, it appears that the DRG system is effective in the shift from inpatient to outpatient service. However, there have been certain disadvantages to this system.

Home health care

Since the "thumb" is a rural area in which many children of elderly people have moved elsewhere, aging patients are forced to fend for themselves. When an elderly patient suffers a disabling illness such as a stroke, there is no family to take care of them at home. With the advent of DRGs, the disabled patient must be transferred out of the hospital into an outpatient setting as quickly as possible. A marked shortage of nursing home and extended care facility beds has led to increased pressure to discharge patients to home care. The lack of available family to care for the patient has led to a virtual explosion of home care corporations. These corporations provide stroke victims with physiotherapy of all sorts, intricate mechanical devices, home-delivered meals and general nursing care. This development is new to this area — whether or not it proves to be cost effective or will indeed be more expensive than the institutional care remains to be seen.

Another problem which appears to be developing with the DRG system and with other cost containment programs is that of the patient who is much sicker than first thought, and who requires a longer hospital stay than the original average suggested. Since this increase in length of stay is not counter-balanced by lesser ill people who require fewer days, the average is increasing. At the present time there is no compensation for this problem.

These problems and others need to be solved, and the question of cost containment and whether it is truly effective must be answered.

Some benefits

One positive effect of DRGs however, is that the medical staff and the administration of the hospital are developing better lines of communication, and are becoming increasingly effective in solving joint problems.

The changes DRGs have brought about in the "thumb" have been markedly profound, especially because our patients are elderly, without family and have to travel a significant distance for medical care. With cooperation on both the medic staffs' and administrations' sides some of the problems may be solved. However, the entire system certainly needs to take a closer look at the issue of cost containment, and how truly cos effective DRGs are when one considers the multiple problems they can create.

Donald C. Smith, MD
Farmington Hills

Much is being written, and a good deal more spoken, about the need for physicians to become more actively involved in the management an governance of hospitals. What is being described as an imperative need is hardly a new phenomenon. Physicians have been active participants in the building, organization and operation of our hospitals for a very long time. Bu relationships between the physician and the hospital in which h or she works have assumed new dimensions and deserve a new kind of attention. In this brief commentary, I would emphasize three points:

1) Effective involvement of th physician in the management an governance functions of the hospital is a qualitative rather tha quantitative matter.

2) The important issues faced by physicians and hospitals toda demand new skills, not commonly encountered in the medical school or hospital administration curricula.

3) A clinical perspective still is important.

Continued on page 33

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Physicians have always recognized the importance of having a direct involvement in the activities of the hospital's governing body. This is where the real power and authority lie. They are sometimes inclined to believe that effective involvement means securing a certain percentage or number of seats "on the Board" and, not infrequently, the number of Board positions assigned to physicians becomes an important issue for negotiation.

As relationships with hospitals continue to change and become increasingly ambiguous, the physician must develop a range of management and socialization skills which will enable him/her to contribute to the survival of the hospital and enable it to take on a forward-looking, "reaching-out" role in the total health care system of the community.

These skills include an understanding of the principles and practice of organizational behavior; integration of institutional mission and philosophy; basic approaches to management, such as communication techniques, negotiation, conflict resolution; and rational approaches to the allocation of limited resources.

"I haven't stopped smoking, but I have stopped enjoying it."

It should not be assumed that these management skills, however polished, can substitute for clinical acumen and an understanding of the epidemiology of health and disease. When the physician moves into a position of leadership in the hospital, the most important assets which he/she will bring to this assignment are a sensitivity to human suffering and despair; an understanding of the natural history of human illness, its likely outcome; the real (versus the theoretical) opportunities for prevention and treatment; and the devastating impact of severe illness and disability upon the family.

In the current surge of interest in the political and economic forces of change which surround the hospital, it is these important considerations which may be overlooked, minimized or disregarded. The physician has both the opportunity and the responsibility of making sure that this does not happen.

The physician can bring a unique perspective to the functions of hospital management and governance. This perspective which focuses on patients and their health care needs can usefully complement the economic, political and organizational concerns which are receiving so much attention at the present time.

Sigurd Janners, MD
Hancock

The effects of diagnosis related groups (DRGs), and in a larger sense the prospective payment system (PPS), have been significant in rural hospitals. The acute care bed occupancy, which has never been very high, is now routinely below 50 percent. This low occupancy rate is the net effect of shorter hospital stays and a slight decrease in total admissions which in turn is the result of a large increase in outpatient services. Three former inpatient services (minor surgery, chemotherapy and transfusions) now are routinely done in an ambulatory setting.

In the hospital where I admit, the decreasing patient census ha necessitated the closing of the intermediate care unit and the layoff of 16 employees. Cardiac patients who need telemetry bu not intensive care and other ver sick patients now are intermingled with the general patient population. I believe this compromises the quality of patient care.

Our hospital is a nine story 110-bed acute care facility. To maintain such a facility for fewer than 50 patients is very inefficie The hospital board of trustees now is exploring the possible c struction of a smaller two-story 60-bed hospital. This would, no doubt, result in significant saving in operating costs, but the financial requirements of new construction will mean that capital expenditures will be drastically cut for the next several years. A new and smaller facility will improve efficiency but will not, in and of itself, add to quality of care.

The introduction of DRGs has also had some positive impact. For example, social services start discharge planning on the day of admission, and placement an outpatient needs, such as physician therapy, are arranged promptly.

I believe that the net effect of DRGs on my patients has been minimal so far. For me as practitioner and consumer, the bottom line will be reached when cost cutting (by whatever pricing system) goes beyond cutting waste and begins eroding quality and limiting access. Then I will speak out with vigor and passion and so must we all.☐

More first-hand experiences with DRGs will be published in upcoming issues.

Before prescribing, see complete prescribing information in SK&F CO.
iterature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ontraindications: Concomitant use with other potassium-sparing agents
uch as spironolactone or amiloride. Further use in anuria, progressive
enal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
otassium. Hypersensitivity to either component or other sulfonamide-
erived drugs.

/arnings: Do not use potassium supplements, dietary or otherwise, unless
ypokalemia develops or dietary intake of potassium is markedly impaired.
supplementary potassium is needed, potassium tablets should not be
sed. Hyperkalemia can occur, and has been associated with cardiac irregu-
rities. It is more likely in the severely ill, with urine volume less than
ne liter/day, the elderly and diabetics with suspected or confirmed renal
sufficiency. Periodically, serum K^+ levels should be determined. If hyper-
alemia develops, substitute a thiazide alone, restrict K^+ intake. **Asso-**
ated widened QRS complex or arrhythmia requires prompt additional
erapy. Thiazides cross the placental barrier and appear in cord blood.
se in pregnancy requires weighing anticipated benefits against possible
azards, including fetal or neonatal jaundice, thrombocytopenia, other
dverse reactions seen in adults. Thiazides appear and triamterene may
ppear in breast milk. If their use is essential, the patient should stop
ursing. Adequate information on use in children is not available. Sensitivity
actions may occur in patients with or without a history of allergy or
onchial asthma. Possible exacerbation or activation of systemic lupus
ythematosus has been reported with thiazide diuretics.

ecautions: The bioavailability of the hydrochlorothiazide component of
yazide' is about 50% of the bioavailability of the single entity. Theoreti-
lly, a patient transferred from the single entities of Dyrenium (triamterene,
K&F CO.) and hydrochlorothiazide may show an increase in blood pressure
fluid retention. Similarly, it is also possible that the lesser hydro-
lorothiazide bioavailability could lead to increased serum potassium levels.
wever, extensive clinical experience with 'Dyazide' suggests that these
nditions have not been commonly observed in clinical practice. Do
riodic serum electrolyte determinations (particularly important in patients
miting excessively or receiving parenteral fluids, and during concurrent
e with amphotericin B or corticosteroids or corticotropin [ACTH]).
riodic BUN and serum creatinine determinations should be made,
pecially in the elderly, diabetics or those with suspected or confirmed
al insufficiency. Cumulative effects of the drug may develop in patients
h impaired renal function. Thiazides should be used with caution in
tients with impaired hepatic function. They can precipitate coma in
ients with severe liver disease. Observe regularly for possible blood
crasias, liver damage, other idiosyncratic reactions. Blood dyscrasias
e been reported in patients receiving triamterene, and leukopenia,
ombocytopenia, agranulocytosis, and aplastic and hemolytic anemia
e been reported with thiazides. Thiazides may cause manifestation of
ent diabetes mellitus. The effects of oral anticoagulants may be
reased when used concurrently with hydrochlorothiazide; dosage adjust-
nts may be necessary. Clinically insignificant reductions in arterial
ponsiveness to norepinephrine have been reported. Thiazides have also
n shown to increase the paralyzing effect of nondepolarizing muscle
axants such as tubocurarine. Triamterene is a weak folic acid antagonist.
periodic blood studies in cirrhotics with splenomegaly. Antihypertensive
cts may be enhanced in post-sympathectomy patients. Use cautiously
surgical patients. Triamterene has been found in renal stones in asso-
tion with the other usual calculus components. Therefore, 'Dyazide'
ould be used with caution in patients with histories of stone formation.
ew occurrences of acute renal failure have been reported in patients on
azide' when treated with indomethacin. Therefore, caution is advised in
inistering nonsteroidal anti-inflammatory agents with 'Dyazide'. The
owing may occur: transient elevated BUN or creatinine or both, hyper-
emia and glycosuria (diabetic insulin requirements may be altered),
eruricemia and gout, digitalis intoxication (in hypokalemia), decreasing
li reserve with possible metabolic acidosis. 'Dyazide' interferes with
rescent measurement of quinidine. Hypokalemia is uncommon with
zide', but should it develop, corrective measures should be taken such
potassium supplementation or increased dietary intake of potassium-
foods. Corrective measures should be instituted cautiously and serum
assium levels determined. Discontinue corrective measures and
zide' should laboratory values reveal elevated serum potassium.
oride deficit may occur as well as dilutional hyponatremia. Concurrent
with chlorpropamide may increase the risk of severe hyponatremia.
um PBI levels may decrease without signs of thyroid disturbance. Cal-
n excretion is decreased by thiazides. 'Dyazide' should be withdrawn
ore conducting tests for parathyroid function.

azides may add to or potentiate the action of other antihypertensive
gs.

etics reduce renal clearance of lithium and increase the risk of lithium
city.

erse Reactions: Muscle cramps, weakness, dizziness, headache, dry
th; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermat-
ical conditions; nausea and vomiting, diarrhea, constipation, other
trointestinal disturbances; postural hypotension (may be aggravated by
hol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias,
rus, pancreatitis, xanthopsia and respiratory distress including pneu-
itis and pulmonary edema, transient blurred vision, sialadenitis, and
go have occurred with thiazides alone. Triamterene has been found in
l stones in association with other usual calculus components. Rare
dents of acute interstitial nephritis have been reported. Impotence has
n reported in a few patients on 'Dyazide', although a causal relationship
not been established.

plied: 'Dyazide' is supplied as a red and white capsule, in bottles of
0 capsules; Single Unit Packages (unit-dose) of 100 (intended for
tutional use only); in Patient-Pak™ unit-of-use bottles of 100.
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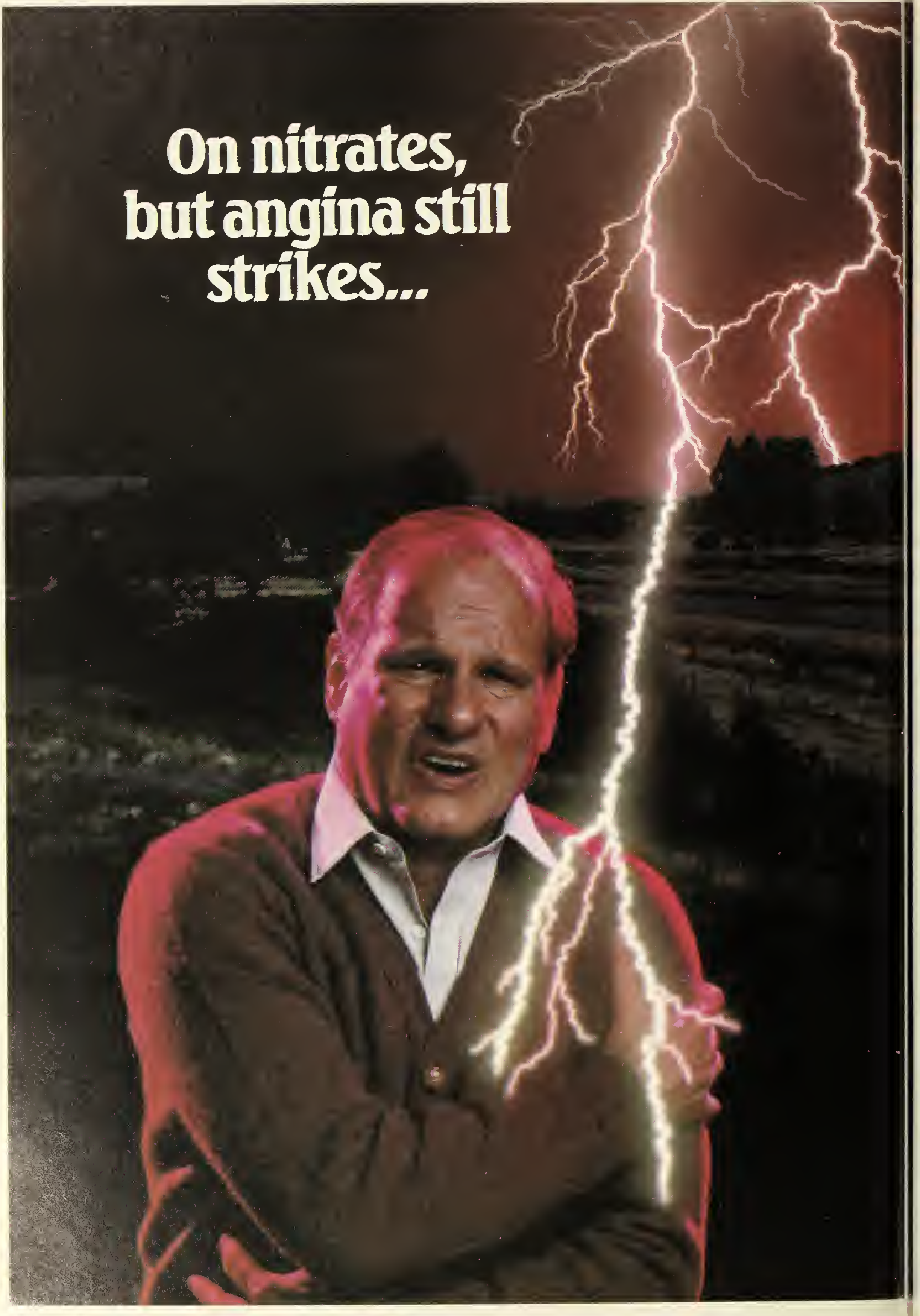
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Please see brief summary on following page.

ISOPTIN®

(verapamil HCl/Knoll)

80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis) Treatment is usually D C -cardioversion, which has been used safely and effectively after ISOPTIN Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina Combined therapy can also have adverse effects on cardiac function Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions Adequate animal carcinogenicity studies have not been performed One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk, therefore, nursing should be discontinued during ISOPTIN use **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1 7%), AV block 3rd degree (0 8%), bradycardia HR < 50/min (1 1%), CHF or pulmonary edema (0.9%), dizziness (3 6%), headache (1.8%), fatigue (1 1%), constipation (6.3%), nausea (1 6%), elevations of liver enzymes have been reported (See *Warnings.*) The following reactions, reported in less than 0 5%, occurred under circumstances where a causal relationship is not certain. ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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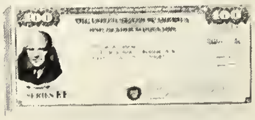

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Usual dosage: See insert

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VELOSEF® FOR ORAL SUSPENSION
Cephradine for Oral Suspension USP

DESCRIPTION: Velosef '250' Capsules and Velosef '500' Capsules (Cephradine Capsules USP) provide 250 mg and 500 mg cephradine, respectively, per capsule. Velosef '125' for Oral Suspension and Veloset '250' for Oral Suspension (Cephradine for Oral Suspension USP) after constitution provide 125 and 250 mg cephradine, respectively, per 5 ml teaspoonful.

INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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VELOSEF® Capsules (Cephradine Capsules USP) | BID

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

HOW SUPPLIED: 250 mg and 500 mg capsules in bottles of 24 and 100 and Unimatic® unit-dose packs of 100. 125 mg and 250 mg for oral suspension in bottles of 100 ml and 200 ml.

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By David C. Nolan, MD

MDPH biologic products division – a hidden asset

The Biologic Products Division (BPD) of the Michigan Department of Public Health MDPH) Laboratories is an asset n this state that we are prone to overlook. The most recent event o bring it to attention was the lap over vaccine shortages, specifically the shortage of DPT Diphteria, Pertussin, Tetanus) vaccine.

When the sole commercial ource for DPT vaccine in the US eported concern about product ability there followed concern bout continued supply of DPT. uthoritative organizations otified their members that cheduled doses of DPT should e delayed to protect the US upply.

But, physicians in Michigan idn't need to worry about the mposition upon good practice ince this state produces its *own* DPT vaccine. With the continued or worsening product liability climate the situation may well reoccur; indeed the commmercial supply may dry up. While hoping for the other 48 states that it does not come to pass, the two states which retain vaccine production capabilities can offer their citizens reassurance.

Michigan's lab, however, currently faces an uncertain future, according to a recent MDPH-commissioned study.

A history of service

It is appropriate that the value of BPD was demonstrated by the DPT vaccine news since the stage was set for control of pertussis through immunization by BPD efforts in the 1920s.

The Biologic Products Divsion carries on its proud tradition primarily in laboratories on North Logan Street across from the MDPH administrative buildings in Lansing. The personnel roster lists about 90 persons and the annual budget is approximately $5 million, two-fifths of which is obtained from grants and contracts rather than from the general fund. The bulk of the BPD's work deals with MDPH-generated projects, and projects supported by, or done in cooperation with, other institutions. The latter assignments may be done through grants or contracts.

Some current work includes:

1. Fractionation of blood products from 65,000 l. of plasma/year resulting in serum albumin, anthihemophilic globulin, interferon, immune globulins
2. Production of DPT, DT, Td vaccines
3. Developement of rhesus monkey tissue culture vaccine for rabies (soon to be released)
4. Anthrax vaccine
5. Anti-botulism products for equine use

Other products being considered or developed relate to

Continued on page 344

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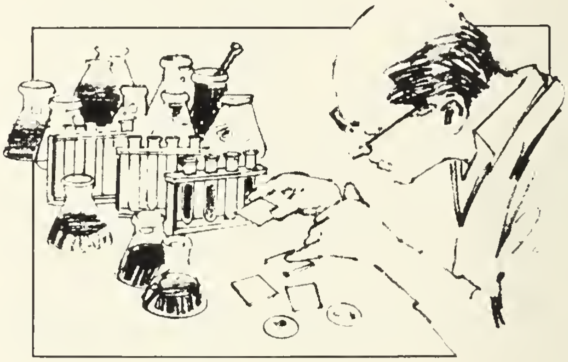
MDPH LAB/Continued

cytomegalovirus, legionaires skin test, botulism in humans, *Hemophilus influenzae*, HTLV VIII, hepatitus, rabies (anti-serum).

An international resource

BPD is a national/international resource, being the sole producer of some of these products and/or sole possessor of an operating facility with requisite expertise. The character of this expertise is evidenced by the grantors, cooperative labs, and correspondents seeking information, such as other biologic production labs, National Institutes of Health, American Red Cross and the World Health Organization.



Most of us have only a small demand for some of BPD's vaccines and products. However, the lab's greatest value lies in the continued work of high quality personnel in the forefront of immunology and immunotherapy developments. Another advantage is the lab's ability to determine which products will be amply supplied by others at tolerable cost, while standing ready to produce products which don't fit into that category.

As an example, consider the dilemma of a physician faced with the decision whether to start post-exposure prophylaxis for possible exposure to rabies. The very considerable out-of-pocket expense, not usually covered by insurance, imposes itself upon the decision-making process. A product, anti-rabies vaccine, produced in rhesus monkey tissue culture, soon will be available from MDPH. It is paid for by ta dollars, so the cost isn't borne b a single family at a difficult time and needn't bias that decision when the patient's life may be i jeopardy. (Production of human source anti-rabies globulin is in the planning stage, for which th same arguments hold.)

Other considerations

A unique feature of this state-run laboratory not appreciated by most of us is that we may communicate to this lab our needs and desires.

Some sober reflections are in order. Isn't this service really a federal obligation? Shouldn't it be left to commercial operators Recent history would seem to speak against both questions.

We've heard laments from a nearby state that in response to budgetary pressures they let the public health laboratory deteriorate. The situation wasn't quite analogous to BPD's, but does point out the danger of letting go of an asset which is taken fo granted and which cannot be easily replaced.

Further questions could relate to the risk/cost of future produc liability suits. Michigan has suffered from some adverse judgments.

Finally, Michigan physicians should consider the costs and benefits of the Biologic Product Divison, and ponder the consequences of losing BPD. They should communicate to BPD an MSMS the improvements, changes, and new products the would like to see.☐

imb-sparing reatment of soft-issue cancer

A National Institutes of Health NIH) consensus development tatement on limb-sparing treatnent of adult soft-tissue saromas and osteosarcomas now nay be obtained from the NIH)ffice of Medical Applications of esearch. It contains recommenations and conclusions conerning limb-sparing treatment f soft-tissue sarcomas and oseosarcomas.

Free single copies of the conensus statement are available om: Michael J. Bernstein, Office f Medical Applications of Reearch, National Institutes of ealth, Building 1, Room 216, ethesda, Maryland 20205. Also vailable is a statement on lowring blood cholesterol to preent heart disease.

eye's Syndrome pdate

One case of Reye's Syndrome S) has been reported in a Michian child since April 1. The total umber of RS cases reported nce October 1, 1984 now ands at ten with three deaths.

Prodrome: (October 1-March 9) Respiratory Illness - 5; hickenpox - 2; Gastroenteritis - ; other - 1. Reye's Syndrome by ounty of residence: one case ach in Berrien, City of Detroit, illsdale, Ingham, Ionia, alamazoo, Monroe, Saginaw d Wayne.

ottle feeding linked ear infections

Bottle-feeding babies on their cks greatly increases the risk ear infection, a University of uthern California pediatrician arns.

"When a baby is fed on its back avity can pull the liquid into the iddle ear," says Susan Tully, MD, sociate professor of clinical diatrics and emergency edicine at the USC School of edicine. "Liquids given orally n travel from the back of the throat via the eustachian tubes to the middle ear. There, the fluid provides a fertile breeding ground for bacteria carried from the nose and throat."

Recurrent ear infections are far more common in bottle-fed babies than breast-fed babies, Doctor Tully says. One reason is that babies who are breast fed are usually held at slightly uphill angle. This position prevents milk from backing up into the ear.

"If you sit babies up for 15 minutes after feeding them on their backs, or if you turn them over on their stomachs, any fluid in the middle ear will usually drain," she says. "If parents would simply turn their children over after feeding, a lot of ear infections could be eliminated."

Truck takes CT scanning on the road

Henry Ford Hospital's Fairlane (Dearborn) and West Bloomfield outpatient centers recently became stops for a truck with a special cargo: a mobile computed tomography (CT) scanner, the first hospital-based mobile scanner in Michigan. The unit, made by General Electric, was put into service in April.

The CT unit will be used to detect brain disorders, aortic aneurysms, liver disease, nerve root compression in the spine, and lymphatic, pancreas, bowel, cervical and lung cancer among other conditions. HFH expects from 3,500 to 4,000 patients per year to be examined using the mobile scanner.

The scanner is housed in an 18-wheel full-sized trailer and will be pulled between the satellites by a conventional truck. Initially, it will operate three days a week at Fairlane and three days at West Bloomfield, with a total operational time of 70 to 90 hours per week.

Special "ports" are being com-

Continued on page 346

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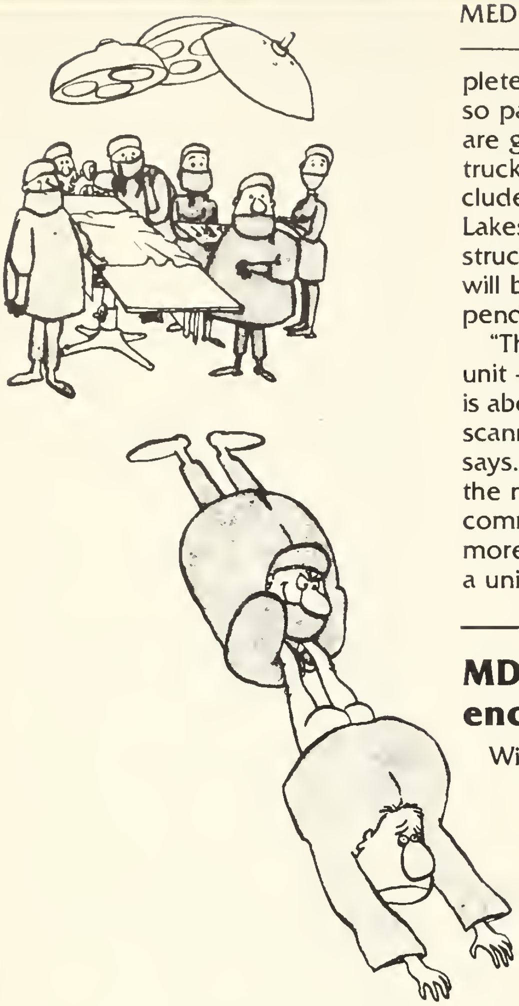

pleted at each of the two centers so patients will never realize they are going from a building to a truck. A port is also being included at the hospital's new Lakeside Center, under construction in Sterling Heights, and will be used for the scanner, pending state approval.

"The total cost for the mobile unit — more than $1 million — is about the same as for one fixed scanner," James H. Thrall, MD, says. "And when you can serve the needs of more than one community with one unit, it's far more cost-effective than buying a unit for each site."

MDPH offers encephalitis tests

With warm weather here, the Michigan Department of Public Health urges physicians to use its encephalitis test services. The MSMS House of Delegates underscored their use when it passed a resolution at the 1985 annual meeting urging members to collect acute and convalescen serum specimens from their patients with summer- and fall-onset viral central nervous syste illness. The acute serum specime is to be collected within the first seven days of onset of illness. Th convalescent serum specimen is to be collected two to three weeks later. The pair of serum specimens should be sent to th Virology Laboratory, Michigan Department of Public Health, along with appropriate patient information and a request for ar-boviral serology: 3500 N. Logan Lansing 48909.

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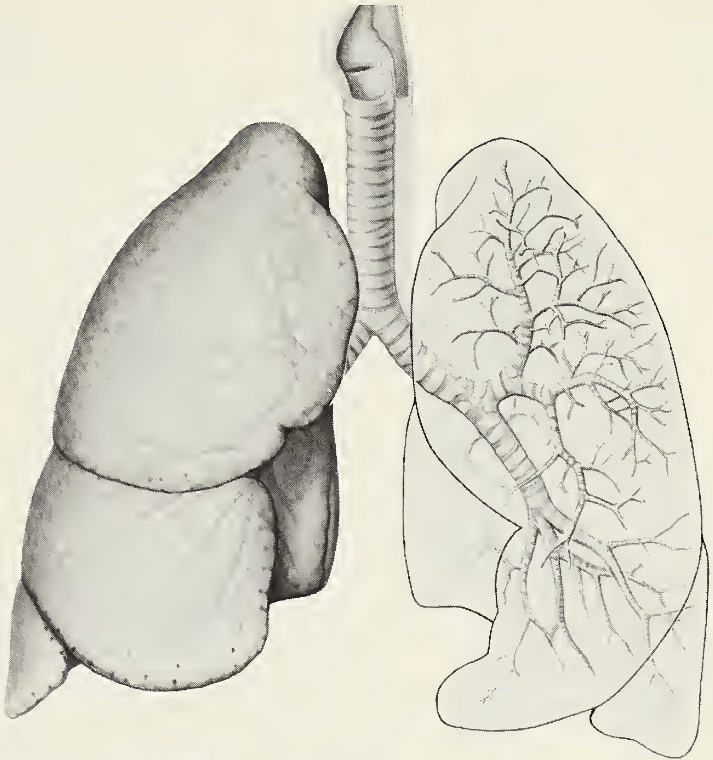

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Brief Summary. Consult the package literature for prescribing nformation.

ndications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the reatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemoph-lus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism o Ceclor

Contraindication: Ceclor is contraindicated in patients with known llergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously o any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal lora of the colon and may permit overgrowth of clostridia. Studies ndicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note. Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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New Medicaid chief, Kevin Seitz, visits MSMS headquarters

In order to get a feel for the concerns of the MSMS Medicaid Liaison Committee, new director of the Medical Services Administration, (the Department of Social Services division that oversees Medicaid) Kevin Seitz, right, sat in on a recent meeting at MSMS headquarters. Seated with Mr. Seitz below are, from left to right, Thomas M. Flake, MD, Cecil R. Jonas, MD, and Jay Endlsey, of OHMA.

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By Rachel Richardson Smit

Abortion, right and wrong

I cannot bring myself to say I am in favor of abortion. I don't want anyone to have one. I want people to use contraceptives and for those contraceptives to be foolproof. I want people to be responsible for their actions; mature in their decision. I want children to be loved, wanted, well cared for.

I cannot bring myself to say I am against choice. I want women who are young, poor, single, or all three to be able to direct the course of their lives. I want women who have had all the children they want or can afford or their bodies can withstand to be able to decide their future. I want women who are in bad marriages or destructive relationships to avoid being trapped by pregnancy.

So in these days when thousands rally in opposition to legalized abortion, when facilities providing abortions are bombed, when the president speaks glowingly of the growing momentum behind the anti-abortion movement, I find myself increasingly alienated from the pro-life groups.

At the same time, I am overwhelmed with mail from pro-choice groups. They too, are mobilizing their forces, growing articulate in support of their cause, and they want my support. I am not sure I can give it.

I find myself in the awkward position of being both anti-abortion and pro-choice. Neither group seems to be completely right—or wrong. It is not that I think abortion is wrong for me but acceptable to someone else. The question is far more complex than that.

Part of my problem is that what I think and how I feel about this issue are two entirely different matters. I know that unwanted children are often neglected, even abandoned. I know that many of those seeking abortions are children themselves. I know that making abortion illegal will not stop all women from having them.

Absolutes: I also know from experience the crisis an unplanned pregnancy can cause. Yet I have felt the joy of giving birth, the delight that comes from feeling a baby's skin against my own. I know how hard it is to parent a child and how deeply satisfying it can be. My children sometimes provoke me and cause me endless frustration, but I can still look at them with tenderness and wonder at the miracle of it all. The lessons of my own experience produce conflicting emotions. Theory collides with reality.

It concerns me that both groups present themselves in absolutes. They are committed and they want me to commit. They do not recognize the gray area where I seem to be languishing. Each group has the righ answer — the only answer.

Yet I am uncomfortable in either camp. I have nothing in common with the pro-lifers. I am horrified by their scare tactics, their pictures of well-formed fetuses tossed in a metal pan, their cruel slogans. I cannot condone their flagrant misuse of Scripture and unforgiving spirit. There is a meanness about their position that causes them to pas judgment on the lives of women in a way I could never do.

The pro-life groups with their fundamentalist religious attitudes have a fear and an abhorrence of sex, especially premarital sex. In their view abortion only compounds the sexual sin. What I find incomprehensible is that even as they are opposed to abortion, they are also opposed to alternative solutions. They are squeamish about sex education in the schools. They don't want teens to have contraceptives without parental consent. They offer little aid or sympathy to unwed mothers. They are the vigilant guardians of a narrow morality.

I wonder how abortion got to be the greatest of all sins? What

Continued on page 359

Rachel Richardson Smith is a student of theology living in North Carolina.

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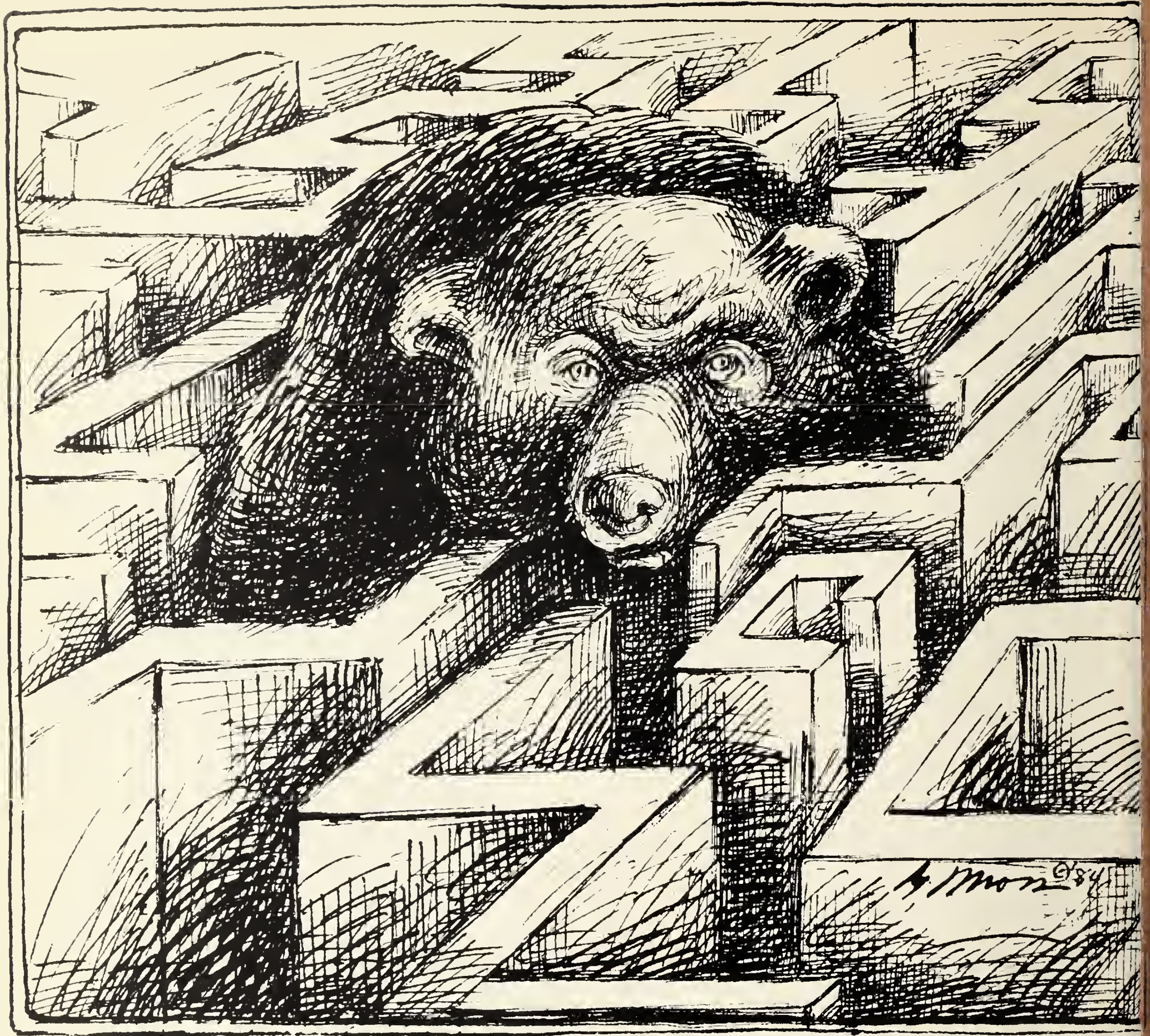

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By Keith S. Henley, MD
Professor of Internal Medicine
University of Michigan Medical School

ACUTE VIRAL HEPATITIS

An educational article and CME quiz

With this article, the MSMS CME Programming Committee continues its medical education feature. A ten-question quiz follows, which may be completed for one hour of Category I credit.

A scientist (Doctor Baruch Blumberg) is examining sera from all over the world, looking for a genetic marker of susceptibility o cancer. In one agar diffusion plate containing serum from an Australian aborigine he sees a band (which may well have been seen before by others, and ignored) and instead of forgetting about it he elects to pursue the phenomenon. Several years later, after false leads are explored, this band is identified as a marker for a common virus of hepatitis (now called Hepatitis B). Within about wo decades he receives the Nobel Prize, and a vaccine against he disease is available. Within a generation Hepatitis B may be no more of a problem than poliomyelitis is now, and even more importantly, the incidence of hepatocellular carcinoma, one of the commonest cancers in the world, is likely to be dramatically owered.

This discovery has resulted in an explosion of information and has permitted other forms of hepatitis to be recognized. The objective of this article is to provide the physician with practical guidelines, and with answers to questions which are commonly asked.

How many types of viral hepatitis are there? The common forms are types A and B which can be serologically diagnosed and therefore differentiated, and non A, non B (of which there are at least two) and which are diagnosed by exclusion. (Other viruses such as those of infectious mononucleosis, herpes Types I and II, may also affect the liver as part of a generalized systemic infection and will not be considered further here.)

Is is possible to distinguish the major types of hepatitis on clinical grounds? In general, no. The clinical course of malaise, anorexia, followed by dark urine, sometimes light-colored stools and jaundice is common to all types. In each the course may vary from the asymptomatic to the fulminant and fatal, although complete recovery is usual. All are characterized by striking transaminase elevations, and, at least initially, by normal serum protein values.

Some clinical features, while not absolutely discriminatory, may be helpful. Hepatitis A is commonest in younger patients. Recovery is complete, death is uncommon, and chronicity does not occur. Hepatitis B is characterized by prolonged prodromata, often with arthralgias and sometimes with a serum sickness-like syndrome. Non A, non B hepatitis often runs a prolonged course, with relapse which may be clinically or biochemically apparent, and sometimes characterized by cholestasis, defined here as elevations of bilirubin and/or alkaline phosphatase out of proportion to transaminase determinations. The incidence of chronic hepatitis due to non A, non B is increasing, as blood donors carrying the hepatitis B virus are eliminated by screening.

What is the route of infection? All viruses of hepatitis can be transmitted by the fecal oral route. Hepatitis B and hepatitis non-A, non-B (NANB) is also transmitted by penetration of skin or mucous membrane; hepatitis A for all practical purposes is not. Given the ubiquitous opportunities of exposure by contaminated food, sexual partners, IV drug abuse, travel in hygienically dubious areas, etc. combined with the lengthy incubation period of weeks or months for each of these viruses, it is often not practical to trace the source of infection.

What are the serological markers of infection of Type A and B and how do I interpret them?

Type A: The virus exists in the blood only transiently, and routine isolation from the feces it not practical. The virus generates antibodies in serum, of the IgM and IgG type. The former is present only transiently (weeks or months) and its appearance indicates present or recent infection with hepatitis A. The latter persists indefinitely so that at middle age half the population of the United States will be positive. Hence, determination of Hepatitis A IgM antibody, and particularly its conversion from present to absent is most helpful.

Type B:

1. Hepatitis B surface antigen (HBsAg): This material is furnished by the liver of the host, does not contain DNA, and is not, in itself infectious. It is however a marker of infection. The antigen appears in the serum at about the time of the prodromata, and generally disappears as jaundice subsides. It may persist for a longer period of time and occasionally indefinitely indicating a carrier state. This accounts for the appearance of the marker in asymptomatic blood donors, or in other routine screening examinations. If therefore, a jaundiced patient, even if clinically suffering from acute viral hepatitis is found to have a positive HBsAg this suggests but does not prove conclusively that the patient is suffering from acute hepatitis B. In this example and in those cited below, *a change* in marker from positive to negative, or vice versa, is a much better indicator of current infection than is provided by a single blood sample. HBsAg may exist with two concomitant antigens:

a. **The e antigen:** This antigen is found only in the presence of hepatitis B. It is present invariably, although usually transiently during the acute attack. If persistent, it will only do so in the presence of chronicity of the disease. Whether the chronicity is clinically significant, i.e. disabling, depends on the presence of symptoms, supplemented where indicated, by a liver biopsy.

b. **The delta antigen:** This is an opportunistic virus which again only exists in the presence of HBsAg. Fortunately it is not an inevitable finding as its presence when occuring with the primary infection results in a much more fulminant and frequently fatal course of the disease. Superinfection with the delta virus may, however, occur in asymptomatic carriers or in patients with chronic hepatitis B. Such superinfection is now recognized as a cause, although not the only one, of exacerbations of chronic hepatitis B.

2. **The hepatitis B surface antibody:** HBsAg generates an antibody (HbsAb) which, when present in sufficient concentration, will confer immunity. In general, in the course of infection, HbsAb will appear at, or shortly after, the disappearance of HBsAg. In contrast to many other forms of infection, the antigen and antibody may co-exist in serum. This may be found in chronic hepatitis, and indicates that immunity, while present is not sufficient to eliminate the virus.

The presence of HbsAb by itself therefore indicates past infection with the virus of hepatitis B. Its presence during the *early phase* of an acute attack of hepatitis indicates that a virus other than that of hepatitis B is responsible for the infection.

3. **The hepatitis B core antibody:** If the surface antigen does not contain viral DNA where then can we test for the presence of the actual virus? The answer is: on a liver biopsy specimen but not in serum. Fortunately viral presence is generally detected by the development of antibody to viral core which circulates in the serum. The generation of core antibody (HBcAb) begins to occur as the HBsAg disappears, and often before the appearance of detectable HbsAb. *For a time therefore, it may be the only marker of the presence of acute hepatitis B infection.* HcAB may persist for months or years and there is a significant but low infectivity associated with its continued presence. Immunity is only conferred once HBsAb in sufficient titre makes it appearance. The continued presence of HbsAb and HBcAb in serum therefore marks the convalescent and/or recovery stage.

4. **Other antibodies:**

a. **Anti-e antibody:** This will appear transiently, as the e antigen is cleared from the serum. It is a marker of *lessened* infectivity and indicates good prospects for complete resolution.

b. **Anti delta antibody:** The presence or appearance of this antibody indicates past infection with the delta virus and its resolution. It is not certain how long this antibody persists in blood.

In summary, the sequential appearance of surface antigen (with e antigen) followed by core antibody and then surface antibody characterizes the normal course of evolution of acute viral hepatitis B. Divergences from that pattern must be evaluated in the light of the findings which led to request for these studies in the first place.

5. **Subdeterminants of hepatitis B:** These are antigenic determinants associated with HBsAg. They are described as being composed of determinant a together with two of d, y, w and r. The clinical importance of these subdeterminants is negligible. They are, however, invaluable in tracking an epidemic to its common source.

When, in acute viral hepatitis is a liver biopsy indicated? If the diagnosis is clear, and the course is as expected, a liver biopsy has nothing to offer and therefore should not be undertaken. If there are questions particularly about the possible development of chronicity, differential diagnosis, or the presence of prior liver disease, a biopsy may be needed. If it is to serve any useful purpose it must be adequate and the pathologist reading it must be skilled in interpretation.

What laboratory tests are available for the identification of the viruses of NANB? None as yet. This is a major gap in our knowledge and vigorous efforts are underway to eliminate it. In the meantime it should be recognized that an individual may be infected by more than one virus of hepatitis during one episode of exposure. This may account for many instances wher the patient's course is atypical and cannot be explained by available markers.

How should the acute attack be treated? Bed rest with bathroom privileges is required as long as the patient is symptomatic. It has been found that a less restrictive regime does no harm in young, previously healthy males, but this has not been extended to females or to older patients. Dietary restrictions, including restrictions in the intake of fat, should not be imposed, and the patient should be allowed to eat as much or as little as they wish. If severe anorexia persists for more than a day or two, or in the presence of vomiting and/or abdominal pain late in the disease, hospitalization and intraenous supplementation be- omes necessary. Hospitalization . also required if the patient, be- ause of social circumstances, annot maintain the required iedical regimen. Corticosteroids re not indicated at any stage of ie acute disease.

When the patient is no longer inically jaundiced, normal ac- vities can slowly be resumed. ie period of convalescence iould be at least as long as the eriod of clinical jaundice, and ven in the absence of symptoms iould be extended if the phys- al demands of the patient's ccupation are unusually strenu- us. Health care personnel gen- rally meet very demanding :hedules.

Treatment of fulminant acute ral hepatitis: Exquisite nursing ire and the prompt recognition id treatment of complications :main the mainstay of treatment. nything else is either of un- roven benefit or, like corticos- roids, probably harmful. En- ephalopathy can be precipitated / sedatives even in small quan- ies, and requires standard treat- ent. Abnormalities in glucose id electrolytes, notably calcium id potassium, should be moni- red and corrected continu- isly. Attempts should be made prevent bleeding from stress cers by intravenous H2-bloc- ers and antacids if these can be lministered. Ventilatory defects ay require intubation, and the itient should be monitored for e development of infection hich may not be clinically ap- irent. Prophylactic antibiotics e not indicated. **What are the ommon errors in diagnosis?** any patients are diagnosed as ffering from acute hepatitis ien by history, physical exami- ition, and laboratory studies, ere is evidence of earlier ronic disease. This would be pported by a long history of igue, amenorrhea, decreased ido, and by findings of ascites, d marked hepatosplenome- ly. Elevations of gamma globu- s are not seen early in the urse of acute viral hepatitis.

Wilsons disease may present a manner which is clinically indistinguishable from acute viral hepatitis. The family history, a Coombs negative hemolytic anemia, the presence of Kayser-Fleischer Rings, and a ceruloplasmin in the low range of normal or below are helpful. This highly treatable disease should be considered in the differential diagnosis of liver disease in all young and middle-aged patients and is not as rare as had earlier been proposed. **How can this disease be prevented, and what kind of prophylactic program is appropriate?** The mainstay of prevention is the liberal use of soap and water by those who have contact with the patient, those whose occupation renders them susceptible to infection (physicians, dentists, nurses, blood bank personnel, attendants in institutions) and those who are known carriers. While the disease is infectious it generally requires close and intimate contact for transmission to occur. Health care personnel and even food handlers who are carriers, and who observe scrupulous personal hygiene, should be allowed to continue in their activities whether or not they are carriers of hepatitis B. Conversely, if they fail to do so, they are negligent regardless whether they are carriers of hepatitis B or not. The point of view which singles out carriers of hepatitis B for special restrictions merely because they are serologically identifiable is lacking in logic. The carrier of hepatitis NANB may be just as dangerous or more so regardless of our present inability to identify such a carrier. Careless personal hygiene is inappropriate in those who by their occupation have the opportunity to infect others. The virus of hepatitis B is only one of many such organisms.

If exposure to a patient with viral hepatitis has occurred (needlestick, sexual intercourse, etc.) passive immunity can be provided by the intramuscular injection of gamma globulin (ISG). This can also be given to travelers proceeding to underdeveloped countries, or who reside in endemic areas for a period of more than a few days. The material is cheap and effective. If there is a high likelihood that the exposure was to the virus of hepatitis B, "hyperimmune globulin" rich in HB_sAB (HBIG) should be given and repeated after about one month. In either event, the first injection should be given as soon after exposure as possible. ISG or HBIG provide passive immunity and may do no more than convert clinically apparent disease to clinically inapparent disease.

The development of a safe and effective vaccine against the virus of hepatitis B represents a major breakthrough. All health care workers who have direct contact with patients or with blood and blood products, all clerical personnel in hospitals, and inmates and staff of institutions where hepatitis is endemic should avail themselves of the protection offered by the vaccine. Others, including immigrants from areas where hepatitis is endemic, individuals with promiscuous sexual habits regardless of their preferences, should likewise be offered this protection. Known carriers of HBsAg are not benefited, but the presence of HbsAb does not necessarily confer immunity, unless the titre is adequate. There is no contraindication to the simultaneous administration of hepatitis B vaccine and HBIG, although generally these are given intramuscularly at different sites. A course of vaccination extends over six months, with additional injections at one and six months.

Very little of this article could have been written 20 years ago. If present progress continues, it is possible that 20 years hence, another such review may contain a totally new body of information, or better still, that the subject of hepatitis like that of poliomyelitis will only be taught in courses about the history of medicine.☐

Turn the page for a Category I CME Quiz

→

CME Quiz

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation certifies that this activity meets the criteria for a maximum of one credit hour in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA provided it is completed as designed.

To obtain one hour of Category I continuing medical education credit, please answer the following questions by circling the correct answer. Mail this page to Sherry L. Fent, MSMS, 120 W. Saginaw Street, East Lansing, 48823. Be sure to include a $3 administrative charge. Deadline: Sept. 1.

True or False:

1. Hepatitis A is a cause of chronic hepatitis. **T F**

2. The clinical course of hepatitis A, B and non A, non B is such that the differential diagnosis can be made with great confidence in the absence of additional serological information. **T F**

3. Every patient with acute viral hepatitis who is HBsAg positive is suffering from acute hepatitis B. **T F**

4. A cook who is found to be HBsAg positive should be summarily dismissed. **T F**

5. A patient beginning to convalesce from acute viral hepatitis may be HBsAg negative and HBsAb negative but still be acutely ill with acute viral hepatitis B. **T F**

6. Every patient with acute hepatitis B who is jaundiced must be hospitalized for treatment with corticosteroids. **T F**

7. HBIG and hepatitis B vaccine can be administerd at the same time. **T F**

*Circle the **only** correct answer:*

8. A 25-year-old patient presents with jaundice, lassitude, anorexia and elevated transaminases. Family history is positive for "nervous problems" requiring hospitalization and resulting in death at a young age. You notice a tremor. The hemoglobin is 8.0% gms and there is no bleeding source. Which of the following represents your best choice?

a. The patient certainly and without a doubt has acute viral hepatitis
b. A close look at the patient' cornea may be informative
c. The patient probably ha chronic active hepatitis
d. The patient is obviously a alcoholic
e. The quickest way to make diagnosis is by liver biopsy

9. A student nurse puncture her hand with a needle which sh has just removed from a patien who is known to be suffering fron hepatitis B. Which of the followin course of action appears appro priate?

a. The patient should receiv HBIG and hepatitis vaccine
b. The nurse should receiv HBIG and hepatitis vaccine
c. The nurse should wash he hands and forget about it
d. The nurse should receive IS
e. The patient should receiv ISG

10. A patient comes to se you feeling unwell, with anorexia lassitude and some arthralgia o one week's duration. You notice slight tinge of jaundice. He tell you that his wife has just bee hospitalized and that a diagnosi of hepatitis B was made.

Which of the following serologic findings are most likely?

a. HBsAb positive
b. HBsAg positive, e antige positive
c. HBcAb positive
d. HB core antigen positive

I wish to apply for one hour of Category I CME through the MSMS Committee on CME Programming. I understand that my answer sheet will be graded confidentially, and that notification of my successful completion of the quiz (80 percent of the questions answered correctly) will be sent to me. I also understand that if I do not answer 80 percent of the questions correctly, I will not be eligible for the one-hour Category I credit but may record and/or report the activity in Category V.

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1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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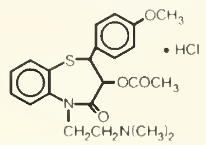

Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect, cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given, a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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bout poverty, ignorance, hunger, veaponry?

The only thing the anti-abortion groups seem to have right is that bortion is indeed the taking of uman life. I simply cannot esape this one glaring fact. Call it vhat you will — fertilized egg, mbryo, fetus. What we have here human life. If it were just a mass f tissue there would be no deate. So I agree that abortion nds a life. But the anti-aboronists are wrong to call it urder.

The sad truth is that homicide not always against the law. Our ociety does not categorically ecognize the sanctity of human fe. There are a number of legal nd apparently socially acceptble ways to take a human life. ustifiable" homicide includes the eath penalty, war, killing in selfefense. It seems to me that as society we need to come to grips with our own ambiguity concerning the value of human life. If we are to value and protect unborn life so stringently, why do we not also value and protect life already here?

Mistakes: Why can't we see abortion for the human tragedy it is? No woman plans for her life to turn out that way. Even the most effective contraceptives are no guarantee against pregnancy. Loneliness, ignorance, immaturity can lead to decisions (or lack of decisions) that may result in untimely pregnancy. People make mistakes.

What many people seem to misunderstand is that no woman wants to have an abortion. Circumstances demand it, women don't. No woman reacts to abortion with joy. Relief, yes. But also ambivalence, grief, despair, guilt.

The pro-choice groups do not seem to acknowledge that abortion is not a perfect answer. What goes unsaid is that when a woman has an abortion she loses more than an unwanted pregnancy. Often she loses her self-respect. No woman can forget a pregnancy no matter how it ends.

Why can we not view abortion as one of those anguished decisions in which human beings struggle to do the best they can in trying circumstances? Why is abortion viewed so coldly and factually on the one hand and so judgmentally on the other? Why is it not akin to the same painful experience families must sometimes make to allow a loved one to die?

I wonder how we can begin to change the context in which we think about abortion. How can we begin to think about it redemptively? What is it in the trauma of loss of life — be it loved or unloved, born or unborn — from which we can learn? There is much I have yet to resolve. Even as I refuse to pass judgment on other women's lives, I weep for the children who might have been. I suspect I am not alone.☐

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William A. Barss, MD
Ypsilanti

Doctor Barss died March 9 at the age of 66. He was a general practitioner in the Ypsilanti area for 38 years, and was a former chief of staff at Beyer Memorial Hospital. Doctor Barss graduated from the University of Michigan Medical School in 1944 and served as a lieutenant in the US Navy's Medical Division during World War II. He was a team physician at Eastern Michigan University from 1955-65, and served as Washtenaw County Medical Examiner.

A. Robert Bauer, MD
Las Vegas, Nevada

Doctor Bauer, formerly of Detroit, died December 14 at the age of 86. He graduated from the University of Pennsylvania Medical School in 1924 and was affiliated with Henry Ford Hospital and Children's Hospital in Detroit.

Joseph W. Christie, MD
Arcadia, Florida

Doctor Christie, formerly of Beaver Island, died on February 13 at the age of 80. Doctor Christie was a medical missionary in Africa for two years and served in World War II and Korea. He was former chief of staff of St. Joseph Hospital in Pontiac and founder and past chief of staff of Leelanau Memorial Hospital. He lived and worked on Beaver Island for 12 years prior to his retirement, and is survived by his wife and four children, one of whom is James Christie, MD, of Pontiac.

A. James French, MD
Ann Arbor

Doctor French died March 15 at the age of 72. He was a Professor and Chairman Emeritus of the Department of Pathology, University of Michigan Medical School. He served on the Surgeon General's staff in Washington, DC. He was named Pathologist of the Year in 1973, and received the Distinguished Service to Pathology award in 1977. He received the Laureate Award in 1984, and had published more than 40 articles. Doctor French was a former trustee, director, president, and executive director of the American Board of Pathology, and he was a former president of the American Association of Pathologists and Bacteriologists, and of the International Academy of Pathology.

Gregory J. Grimaldi, MD
Roseville

Doctor Grimaldi, 80, died February 14. He graduated from Marquette Medical School in 1933, and was a lieutenant commander in the US Navy during World War II. He was affiliated with St. Joseph Mercy Hospital in Detroit and he retired in 1966.

John R. Horn, MD
Grand Rapids

Doctor Horn, 46, died February 23. A rheumatologist and internist, he graduated from the University of Missouri Medical School in 1964. He was a full clinical professor at MSU, and in 1976 he was cited for teaching excellence. He was a Fellow of the American College of Physicians and past program director for internal medicine at Blodgett and St. Mary's hospitals.

Robert D. Isgut, MD
West Bloomfield

Doctor Isgut, a Detroit pediatrician, died February 22 at the age of 60. He graduated from the University of Buenos Aires Medical School in 1952. After moving to the US , he joined the staff of Children's Hospital of Michigan.

Philip R. Johnson, MD
Mt. Pleasant

Doctor Johnson died February 16 at the age of 81. After graduating from the University of Michigan Medical School in 1931, he moved to Mt. Pleasant where he joined the staff of Central Michigan Community Hospital, where he remained until his retirement in 1979. He served the regional center for developmental disabilities, and was employed by Central Michigan University for more than 10 years.

Ksenia L. Lebedovych, MD
Union Lake

Doctor Lebedovych died at the age of 80. After studying medicine in Austria, Poland, and West Ukraine, she moved to the United States, was licensed in Michigan in 1955 and practiced in Lapeer County until her retirement.

John T. Manwaring, MD
Flint

Doctor Manwaring, Flint psychiatrist, died January 31 at the age of 75. After graduating from the Northwestern University Medical School in 1942, he became a Captain in the US Army where he served until 1946. He practiced psychiatry at Traverse City State Hospital and at the Veteran's Medical Hygiene Clinic in Detroit before starting a private practice in Flint in 1952. He was a former director of the Department of Psychiatry at Hurley Medical Center, and assistant clinical professor of psychiatry at MSU College of Human Medicine.

Josefina A. Mariano, MD
Dearborn

Doctor Mariano, Detroit oncologist, died February 3 at the age of 55. A native of the Philippines, she graduated from Manila Central University in 1956 and practiced in the Islands until 1959. Then she moved to the US and settled in Chicago. Doctor Mariano moved to the Detroit area in 1972 and became affiliated with the Veterans Administration Hospital in Allen Park and the Wyoming Health Center of Metropolitan Hospital in Dearborn.

Lester E. McCullough, MD
Grosse Pointe Woods

Doctor McCullough died March 23 at the age of 75. He was an ophthalmologist affiliated with Harper Hospital in Detroit and an assistant professor at Wayne State University Medical School. Doctor McCullough retired in 1974.

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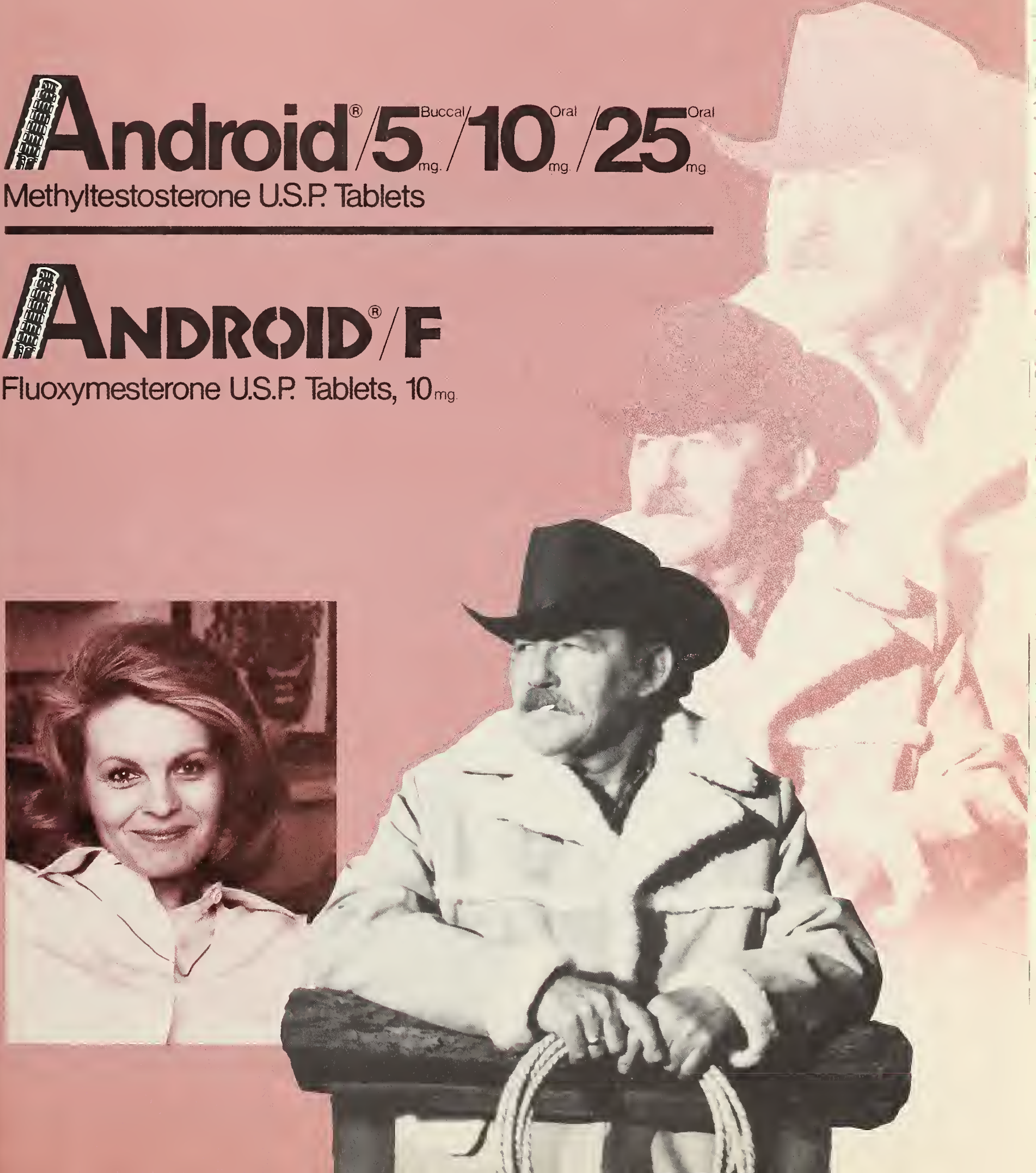

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Here are photo highlights of 1985 House of Delegates — April 26-28

Robert D. Burton, MD, left, and Gerald H. Mandell, MD, right, Vic speaker and Speaker of the Hous of Delegates, respectively, look o from the podium as the delegate discussed the resolutions before them.

Willard Stawski, MD, left, and Kornelius Van Goor, MD, both of Grand Rapids, discuss a vote on the floor.

Immediate past-president Louis R. Zako, MD, left, drapes a strand of met plates etched with names of previous MSMS presidents around the neck Richard J. McMurray, MD, MSMS president for 1985.

ewly-named MSMS president-elect Thomas R. erglund, MD, right, congratulates Warren F. Tryloff, ho served as MSMS Executive Director for more than years, as the delegates named him an honorary legate of the society's governing body.

Paul Allen, former Michigan Medicaid chief, was honored during the proceedings with a Presidential Citation for his longstanding support of and work toward excellent health care in the state.

A presidential candidate John Coury, MD, Port Huron, left, attended the SMS direction-setting session, and shared a table with Charles Oakes, MD, st MSMS Plessner Award winner.

Vivian Lewis, MD, left, reference committee chairperson, and Cathy Blight, MD, alternate delegate, discussed the issues between themselves and with other concerned physicians.

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June 13-17 — AMA Hospital Medical Staff Section Fifth Assembly Meeting, Chicago, contact: Dewitt C. Miner, Department of Hospital Medical Staff Services, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

June 16-20 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 18-20 — MSMS Board of Directors Midsummer Meeting, Hidden Valley Resort, Gaylord, contact: William Madigan, MSMS headquarters.

September 18-19 — AMA 1985 Political Education Conference, Washington, DC, contact: AMA Division of Political Education, 1101 Vermont Avenue, NW, Washington, DC 20005. (202)842-8442.

October 17-19 — AMA National Medical Staff Conference, Sheraton Washington Hotel, Washington, DC, contact: Karen Prupes, (312) 645-4418.

OTHER MEETINGS

July 24 — Michigan Chapter, American Council of Surgeons - Council, Park Place Hotel, Traverse City, contact: Viola M. Heins, (517)337-1351.

July 24 — Michigan Psychiatric Society Council Meeting, Inn on the Park, Toronto, contact: Michigan Psychiatric Society, 21700 Northwestern Highway, Suite 1175, Southfield 48075.

August 2-4 — Summer Seminar of Michigan Medical Assistant Journal, Hyatt Regency, Flint, contact: Michigan Medical Assistant Journal, 6724 Cooper, Lansing 48910.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313) 839-3011.

September 18 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola M. Heins (517)337-1351.

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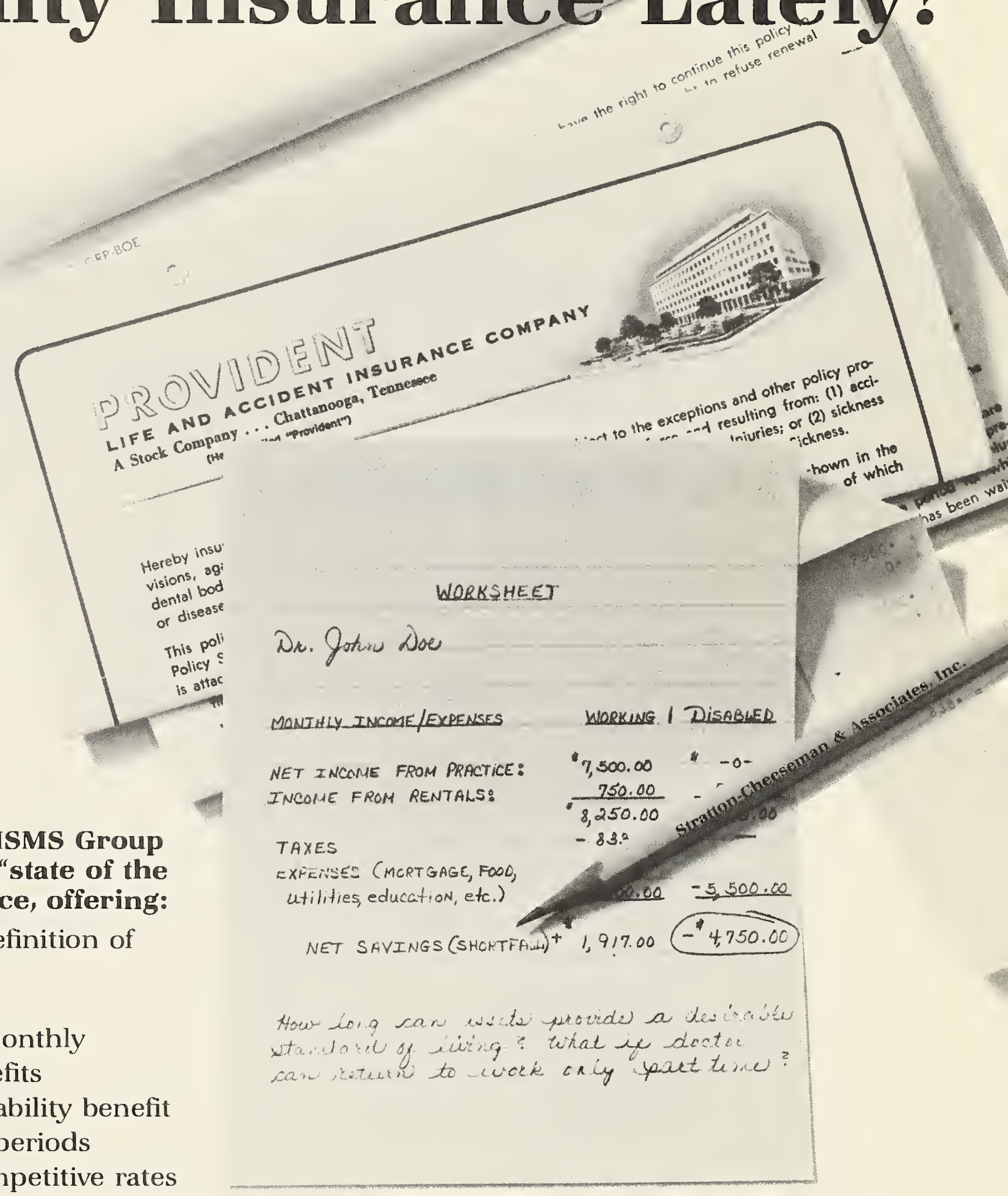
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MPMLC assists pathologist researching infant defects

By Dan Troutma

A Michigan pathologist is continuing research aimed at pinpointing the cause of a placental aberration associated with stillborn and abnormal infants with help from the Michigan Physicians Mutual Liability Company (MPMLC).

The MPMLC Board of Directors contributed $5,000 in December to the Michigan Placental Tissue Registry (MPTR) under the direction of Charles Sander, MD, at Michigan State University. In addition, Robert Leitch, MD, MPMLC president and chairman, wrote 34 physician-owned professional liability companies, urging them to join in the effort to maintain financial support for Doctor Sander's work at the MPTR. Among the practical applications of Doctor Sander's research, the MPMLC board saw his findings helpful in identifying the cause of death in "bad baby" cases.

Doctor Sander's research is of critical value to the medical community. It shed light on the complex problem of accurately establishing the causes of stillbirths and abnormalities. . . .It may very well provi a possible defense in certain 'bad baby' cases which presently are lumped into various categories.

"We believe Doctor Sander's research is of critical value to the medical community, especially physicians who do obstetrics," Doctor Leitch said. "It shed light on the complex problem of accurately establishing the causes of stillbirths and abnormalities of newborn infants, an area of medicine where more reliable information would help physicians and patients. In addition, it may very well provide a possible defense in certain 'bad baby' cases which presently are lumped into the categories of 'birth injur 'perinatal anoxia,' 'hypoxic encephalopathy,' etc."

At the time of the MPMLC board's action, Doctor Sander's investigation into placentas associated with medical problem was jeopardized because instit tional research grants were expiring. In the past, the MPTR h been funded by the Michigan public health and mental healt departments and United Cereb Palsy Association of Michigan, Inc.

Currently, operation of the MPTR mainly is being sustainec by $17,000 contributed so far

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Mr. Troutman, East Lansing, is communications manager for Stratton-Cheeseman Management Co., Inc., which oversees administration of Michigan Physicians Mutual Liability Company.

hysician-owned professional ıbility companies. Donors to ate include doctors' insurance ompanies from California, rizona, Illinois, and Mississippi. octor Sander is hopeful that he ın obtain a one-year grant from e National Institutes of Health, ethesda, Maryland, beginning May, 1986. Until then, how- ver, the MPTR must come up ith about $50,000 beyond the ntributions of physicians' in- rance companies to continue search projects.

"I'm just not going to drop it," octor Sander said. His top prior- now is conducting larger udies to validate MPTR pilot ojects. In those early projects, octor Sander uncovered the istence of hemorrhagic en- ovasculitis (HEV), and estab- hed links to stillbirth, growth tardation, and developmental fects.

Located in MSU's Pathology epartment, the MPTR is a diag- stic referral center which re- ives more than 1,000 placental ecimens annually from Michi- n and out-of-state hospitals. It the largest registry of its kind the nation. Physicians refer centas to the MPTR in cases abnormal pregnancy, labor or livery; maternal illness; fetal or cental abnormality; and birth. Reports generated at the TR are returned to the refer- g physician and correlate pla- ntal abnormalities with clinical oblems.

IEV, which Doctor Sander first covered, involves damage to, destruction of, fetal placental od vessels, red blood cells, l hemorrhage within the centa. In-depth studies utiliz- the electron microscope gest that an infectious agent agents may be involved. Viral *Mycoplasma*-type particles e been found in 44 percent bnormal cases examined. Al- ed placental cells with inclu- bodies have been recog- ed in 12 percent of affected centas.

1981, Doctor Sander and ociates established a significant relationship between HEV and stillbirth in a pilot case-control study of placentas referred to the MPTR over a two and a half year period. Two hundred eighteen placentas with HEV were identified and matched with 400 controls from a total of 1,148 placentas referred to the MPTR. The pilot study revealed that of the placentas with HEV, about 52 percent of the infants were stillborn. However, the incidence of stillbirth among infants from the control group was only 22 percent.

Secondly, Doctor Sander found a significant association between placental HEV and intrauterine growth retardation of infants. The birth weight of infants whose placentas were affected by HEV was in the lowest decile in 33 percent of the cases compared to 19 percent for controls.

Doctor Sander and associates established a significant relationship between HEV and stillbirth . . .

Thirdly, he found in a group of 28 mothers whose first placentas evidenced HEV that HEV recurred in a subsequent placenta in 46 percent of the cases. The recurrence rate is greater than the 19.4 percent occurrence rate of the lesion in all cases, suggesting a recurrence risk for this process. In addition, the pregnancy outcome in the recurrent cases was worse with respect to fetal morbidity and mortality than that of the general registry population.

Doctor Sander and associates, including a group at the Mott Children's Health Center in Flint, initiated a follow-up study of 5-year-olds whose placentas were affected by HEV to investigate long-term effects on their growth, development and health status. The study of 15 children whose placentas were affected by HEV showed a higher incidence of developmental defects than among a control group. Forty percent of the HEV-affected 5-year-olds evidenced abnormalities affecting the central nervous system, including cerebral palsy, optic atrophy, hearing impairment and learning disability risk. The incidence of developmental defects among controls was only 14 percent, one case each of very short stature and a ventricular septal defect. Tests for cognitive skills revealed significant differences between case and control groups.

Preliminary findings of a 1984 follow-up clinical and epidemiological study of 40 HEV-affected infants and their mothers support earlier MPTR results. The incidence of health and developmental defects among HEV-affected 5-year-olds was 25 percent, compared to 11.1 percent for in-registry controls, and zero percent among community controls.

Ultrastructural and immunopathological studies of placentas that Doctor Sander has conducted in the past year have confirmed the presence of viral, virus-like, and *Mycoplasma*-type particles in a high percentage of HEV cases. His tentative conclusions regarding the cause of HEV are: (1) that a synergistic effect between infectious agents may be involved, and (2) that there may be a suppression of the immune response in utero, possibly secondary to the action of a specific virus.

Additional in-depth pathological studies are needed to establish HEV's cause, risk factors and means of prevention, Doctor Sander said. Another of his objectives is to train more pathologists in the science of analyzing placentas; only about 5 percent of pathologists are skilled in evaluating placental tissue, he said.

Meanwhile, Doctor Leitch and MPMLC staff are continuing efforts to obtain support for MPTR research through the network of physician-owned medical professional liability companies.☐

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: June 20-22, 35th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Resort. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 15 hours of Category I

Date: June 22, Cardiovascular Diagnosis and Decision Making for the Primary Care Physician. Location: St. Clair Inn. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076. **Approved for:** 5 hours of Category I Credit.

Date: June 23-28, An Update on Common Clinical Concerns. Location: Hilton Shanty Creek. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Office of Continuing Medical Education, Towsley Center, Box 057, The University of Michigan Medical School, Ann Arbor, MI 48109-0010, (313)763-1400. **Approved for:** 20 hours of Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for:** 21 hours of Category I Credit for MDs and DOs.

Date: August 24-27, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center - Box 057, University of Michigan Medical School, Ann Arbor 48109 (313)763-1400. **Approved for:** 10 hours of Category I Credit.

Date: August 29-31, Controversies in Obstetrics and Gynecology. Location: Grand Hotel, Mackinac Island. **Sponsor:** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and
Gynecologists, 600 Maryland Avenu
SW, Washington, DC 20024. **Approve**
for: 16 hours of Category I Credit.

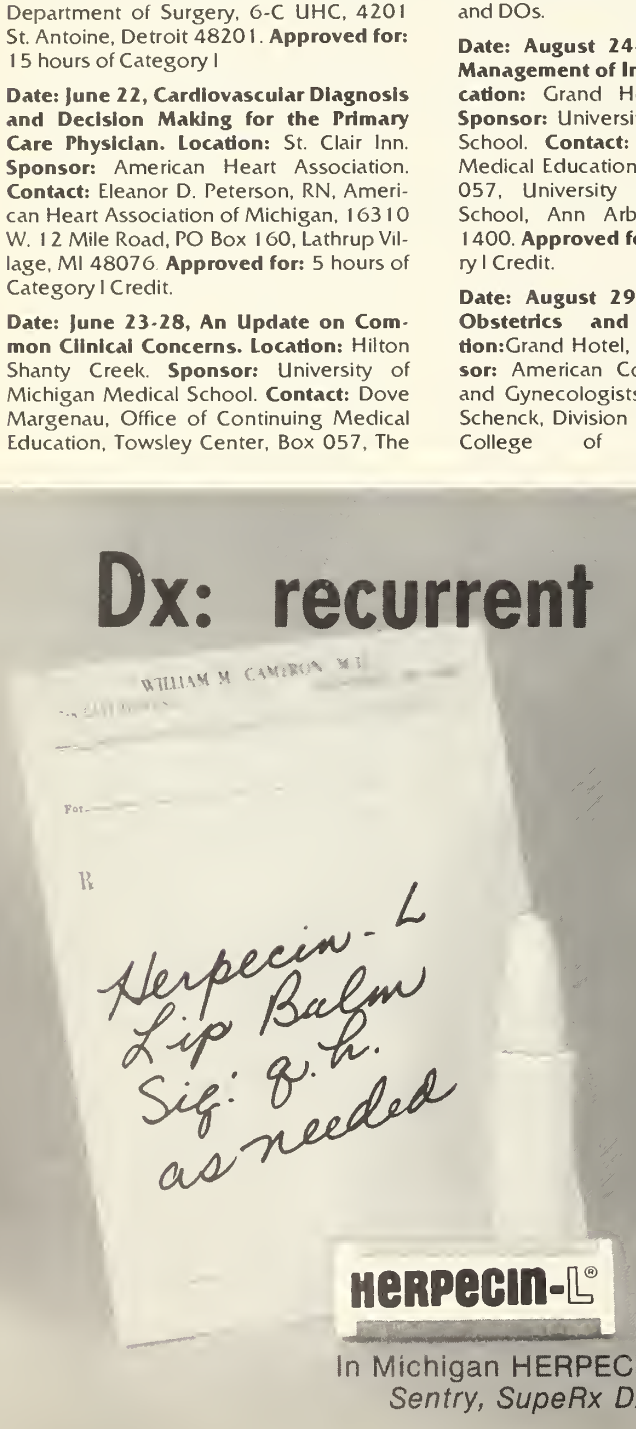
Date: September 4-8, Tutorial on Fund
mentals of Muscle Energy Diagnost
and Manipulative Technique. Locatio
Kellogg Center, MSU. **Sponsor:** MSU Co
lege of Osteopathic Medicine and Co
lege of Human Medicine. **Contact:** San
Kilbourn, Director of Continuing Medic
Education, MSU, East Lansing. (517)35
9714 **Approved for:** 40 hours of Categ
ry I Credit for MDs and DOs.

Date: September 12-14, ACLS - A
vanced Cardiac Life Support. Locatio
Genvieve U. & Donald S. Gilmore Cent
for Health Education, Kalamazoo. **Spo**
sors: Bronson Hospital Life Support O
fice & Southwestern Michigan Are
Health Education Center. **Cost:** $25
Contact: Cyndi Kochevar Bouma, Brons
Methodist Hospital, Life Support Offic
252 E. Lovell, Kalamazoo 490
(616)383-7576. **Approved for:** 20 hou
of Category I Credit.

Date: September 16-18, Trauma to t
Hand: Diagnosis, Treatment and Fun
tional Restoration. Location: Towsl
Center, Ann Arbor. **Sponsor:** Americ
Society for Surgery of the Hand. **Conta**
American Society for Surgery of the Han
3025 South Parker Road, Suite 65, Auro
CO 80014, (313)755-4588. **Approve**
for: 16.5 hours of Category I Credit.

Date: September 18, Primary Ca

Dx: recurrent herpes labialis



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ledicine. Location: Henry Ford Hospital,)etroit. **Sponsor:** Henry Ford Hospital. **:ontact:** Henry Ford Hospital, Continuing ledical Education, 2799 W. Grand Blvd.,)etroit 48202 (313)876-3073. **Ap- roved for:** 6.5 hours of Category I Credit.

ate: September 27-29, Eighth Annual ourse in Diagnostic Ultrasound. Loca- ion: Towsley Center for Continuing Med- al Education. **Sponsor:** University of lichigan. **Cost:** Approx. $295. **Contact:** lene Glaspie, The Office of Continuing ledical Education, The University of lichigan Medical School, Towsley Center, ox 057, Ann Arbor 48109-0010 13)763-1400. **Approved for:** 15 hours f Category I Credit.

ate: September 29-October 1, Tutorial n Myofascial Release Technique. Loca- on: Kellogg Center, MSU. **Sponsors:** ISU College of Human Medicine and Os- eopathic Medicine. **Contact:** Sandy Kil- ourn, Director of Continuing Medical ducation, MSU, East Lansing. (517)353- 714 **Approved for:** 24 hours of Catego- I Credit for MDs and DOs.

ate: October 4-6, Technological Ad- ances and the Anesthesiologist. Loca- on: Amway Grand Plaza, Grand Rapids. **ponsors:** Michigan Society of Anes- esiologists and University of Michigan epartment of Anesthesia. **Contact:** aroline Rich, MSMS Headquarters, East nsing. **Approved for:** 7 hours of Cate- ry I Credit.

Date: October 5-6, The Geriatrics Challenge, The Medical Response. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic. **Contact:** Kay Kelly, (616) 383-4500. **Approved for:** 12 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 20 hours of Category I Credit.

Date: October 11-13, An Affordable Prescription: Knowledge, Comradery, and Relaxation. Location: Grand Traverse Resort. **Sponsor:** American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 19, Common Problems with Coronary Artery Disease. Location: Somerset Inn, Troy. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076 (313)557-9500. **Approved for:** 7 hours of Category I Credit.

Date: October 21-25, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. 18 Category I Credits applied for.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

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ANN ARBOR-DETROIT AREA: Looking for career-oriented emergency physicians board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Excellent compensation including malpractice insurance. Contact: Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

TOLEDO: Family physician to assume practice at hospital affiliated clinic in southeastern suburban community. Excellent guaranteed start-up salary and lease arrangement. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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By Richard J. McMurray, M

The corporate transformation of American medicine

The following is excerpted from the address delivered by Doctor McMurray when he was installed April 27 as MSMS president. It is the first of a two-part series taken from the address, which explored changes and challenges in medicine.

Perhaps we have tried to do too much in the development of better health care. Have we priced ourselves out of the marketplace? In our attempt to provide quality and access, have we stretched the third arm of the triangle—cost—to its breaking point?

Data contained in a report by Henry Aaron and William Schwartz for the Brookings Institute in the book, *The Painful Prescription*, gives us an alternative. It indicates that the standards for treatment now utilized in Great Britain, if applied to the people of the United States, would lead to 37,000 more deaths per year from renal disease; 48,000 more deaths from cancer; 40,000 from coronary artery disease.

In our country, we have spent 30 to 40 years searching for ways to assure access to, and availability of, quality medical care and hospital services for all. Then, about eight years ago, the country turned its focus to how to reduce the escalation of the cost of medical care. Now, in 1985, we have progressed to the point where the question is how to limit access, how to decrease demand, how to ration care. These alternatives are not acceptable.

In the emerging world of PPOs, TRUST, PROs, DRGs, and other alternative health care delivery systems, our 'shaping' is crucial.

Sometimes we think of ourselves as victims, but our patients may really be the victims. We must remain the advocates for our patients and we will only become victims if we allow it!

Being an advocate for our patients is basically part of our medical ethics, and I quote, "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." The Judicial Council of the AMA also states, "While physicians should be conscious of costs and not provide or prescribe unnecessary services, social policy expects that concern for the care the patient receives will be the physician's first consideration."

Economics, the rising cost of medical care, have driven deeply into discussions of social policy and medical ethics. It has happened because modern medicine is both labor-intensive and technology-intensive. Modern medical practice takes lots of highly trained, skilled people, and a lot of expensive equipment. This means money!

Although high cost care does not necessarily equate into high quality care, high quality care does usually equate into high cost care. That is why the total health care bill for this country is running about $320 billion a yea — more than 10 percent of the gross national product.

Uwe Rheinhart, the Princeton economist, maintains that health care costs could reach as high as 14 percent of GNP and still be acceptable, but not to the third party payors.

As I stated previously, ethically our responsibility is to the individual patient. Today however, there is a movement that says the physician's first obligation is to society. This kind of thinking has come from the need, which all of us recognize, to help control the cost of medical and health care.

Yet, when we consider the fastest-growing segment of our population is people over 65 years of age, how much control can we expect?

A real challenge

Profit-making organizations in our free enterprise system now have become an acceptable par of the medical care system. A rea challenge is posed when the policy of the medical practice corporation begins to dictate how individual physicians deal with and treat any particular patient. The corporate transformation of American medicine brings with the inevitable point where the profit interest for the investor conflicts with the health interest of the patient.

Do you suppose it is possible that someday our basic creed o primum no nocere—first, do no harm—will be changed to "first, low cost?"

The answer is: not if we physicians maintain strength in our organizations at all levels—county, state and national—and establish policies and principles that will guide our profession to successfully and ethically meet the needs of our patients.☐

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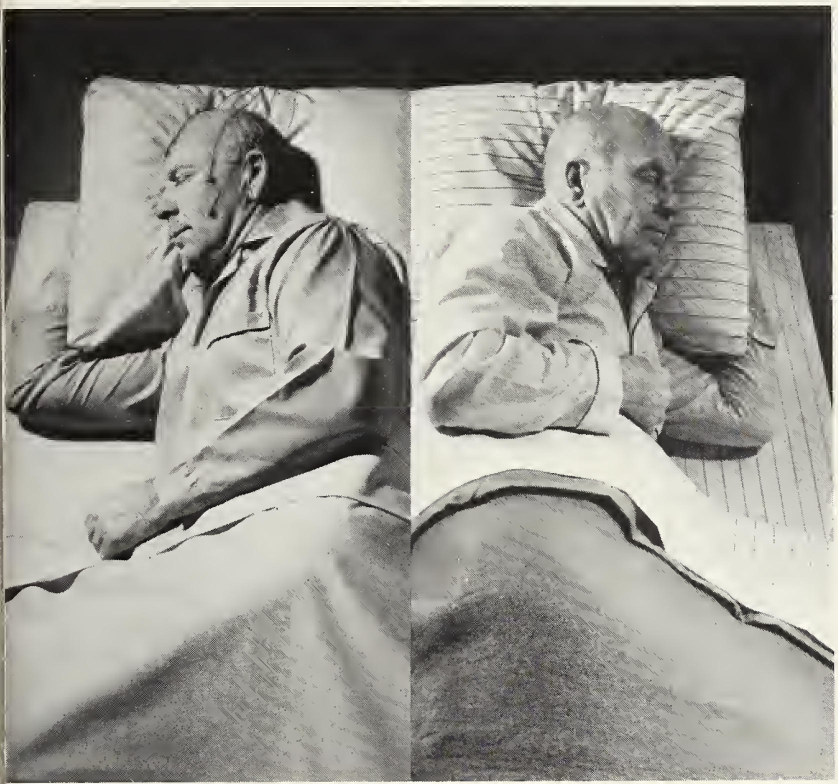

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